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## The Jackson Lecture.<sup>1</sup>

### THE PLACE OF HISTORY IN WAR AND POST-WAR PROBLEMS.

By JOHN BOSTOCK,  
Brisbane.

MIND may be regarded as the personal window through which each one of us looks at the universe. No two views are identical. One man sees a stretch of little nothings, another views a vista of unutterable weariness, and a third is dazzled by countless scenes of beauty.

Tonight I have the honour of addressing you in memory of Dr. E. Sandford Jackson. His was one of those rare minds which showed life as a great panorama, not merely on the three dimensions which suffice for the majority, but also on that fourth dimensional plane on which the few perceive the moving hand of time. Without doubt Sandford Jackson must be regarded as one of the immortals, for by his historic researches he has lit a torch which will not be extinguished through the years. He will be remembered chiefly as an historian who has not merely written valuable contributions on many subjects, but has preserved much priceless material upon which other hands may labour.

I have a feeling that were Sandford Jackson with us today his mind would be concerned with the significance of world events. He would be imbued with the desire to weave the story of history into those colossal happenings which are today shaking our social fabric. Whilst fully aware of our immediate need for victory, he would refuse to regard this world war as an event outside the ambit of the historian. Instead he would ask: "What does the past

indicate in the elucidation of today's events?" "Can history tell us what tomorrow will bring?" "Will it help us so to alter our way of life that there will be an end to the periodic cataclysm of war?"

Tonight I propose to answer some of these questions and make no apology for digressing from the purely medical angle. Whilst specialism is essential, ultra-specialism is a calamity. It may be said with justice that much of the world chaos is due to ultra-specialism. Each profession, each trade, each calling, has extracted such whole-hearted support from its votaries that little has been left for politics and government. Through this neglect social disease has riddled the cumbersome body of civilization. In this connexion our own profession has not been blameless. Few of its members have distinguished themselves in the sphere of government. The majority has left such matters to others, forgetful of the age-old truism "we reap what we sow", and its corollary "the harvest of complacency and indifference is chaos, war and destruction".

### Historical Retrospect.

Before proceeding further, we must ask ourselves a very pertinent question: "Is it reasonable to presume that the lessons of history are applicable today?" Mankind has evolved and invented such a tremendous number of new gadgets that he may be excused an occasional thought that our times are unique, and do not fall within the scope of history. Actually this is not the case. Whilst some of the material etceteras of life have altered, the mind and body features which lie at its core have made few changes. To illustrate this I propose to reconstruct a visit to the Moreton Bay Hospital in the forties of last century.

The incidents are taken from the case books which are still extant, largely through the foresight of Sandford Jackson whom we honour tonight. Permission to use this material was kindly given by Mr. T. L. Jones, late Chairman of the Brisbane and South Coast Hospitals Board, and Dr. Aubrey Pye, Medical Superintendent.

<sup>1</sup> Delivered at a meeting of the Queensland Branch of the British Medical Association on September 4, 1942.

In the first bed is a male, aged twenty-seven years. Our notes tell us that on admission:

"He had been in a bad state of health for some time. Two days ago was suddenly seized with pain about the region of the pubis which gradually extended up the abdomen and at length lodged in the stomach. His jaws shortly afterwards became stiff so that he could not open his mouth. He became also affected with Opisthotomy, his head being drawn backwards on his being raised to the upright posture. The man is much emaciated. He complains on admission of pain in the gastric region. His jaws are rigid, so that his mouth can with difficulty be opened so as to admit the giving of nourishment or the administration of medicine. Pulse small and wiry. Countenance shrunk and rather flushed."

Two days before he was "much the same and has swallowed a little tea—no sleep—bowels not moved since admission".

Yesterday he had "a bad night—was nearly choked in attempting to swallow a small pill with a little wine—clonic spasms came on at intervals—jaws extremely rigid—body bent backwards—countenance anxious—face puckered—pulse rapid and soft—perspiration copious—has severe pain in the epigastrium extending to spine—thirst urgent".

We notice that his "jaws extremely rigid—cannot swallow anything—the attempt tends to bring on violent spasms—appears getting weaker—pulse wiry and scarcely perceptible—extremities becoming cold". He actually died a few hours later at 8 p.m.

In the next bed is a private soldier, aged twenty-five years. We are told that he "was picked up on the Windmill Hill this morning, having been lying there all night—had been drinking with a party overnight, and consumed an immense quantity of strong rum—when brought to hospital was still in a state of intoxication—free pulse, extremities cold—face pale, pulse scarcely perceptible—smelt very strongly of spirits".

His neighbour is aged forty years. We read that he "complains of a feeling of weakness and faintness which comes over him occasionally. His appetite is tolerably good and his bowels pretty regular, although at times inclined to be constive—complaints began about six weeks ago and came on gradually—the pulse is regular and heat of the skin natural. Has been going on favourably for the first few days, feeling much better, but last night he was seized with a dull heavy sensation over all his body, more particularly in the head, which continues this morning—appears to be affected with the prevailing influenza."

I think you will agree that in spite of the lapse of almost 100 years, the phraseology used in the description of these three cases would be applicable today. We can easily recognize one of tetanus, a second of acute alcoholic intoxication, and a third shows the development of influenza in a neurasthenic.

If we glance through the treatment sheets it is apparent that many medicines used in that era still find a place on our dispensary shelves. There are "Tinct. Opii", "Ether Sulph.", "Mist. Camph.", There are "Spt. Ammon. Aromat.", "Pulv. Ipecac. Co.", castor oil and "Decoction Cinchona".

A glimpse into the hospital letter book about the same period shows that the similarity between the past and present is not confined to physical signs, symptoms and treatment. We record the liberal employment of red tape. Years passed before the finances of the hospital were adjusted. As New South Wales was the first settlement, it possessed the first hospital, and therefore admitted cases from far and wide. For financial backing the Sydney Benevolent Society received fines which were paid into the Court of Petty Sessions from such distant places as Drayton and Warwick in Queensland, though their sick people were sent to the Moreton Bay General Hospital. The tradition that all money collected from fines should go to Sydney was so strong that very forceful representations had to be made before the anomaly was rectified. Here again I think you will agree that there is a very modern note. The advent of wireless, the teleprinter and the telegraph has not dispersed the red tape and vested interest

present in the days of the bullock cart and coach. We might continue much further on this theme, which I trust is sufficiently documented to illustrate life's essential similarity through a century.

Sandford Jackson has presented us with a classic example of a social trait which has existed in every civilization and is still present today. I refer to neophobia or fear of new ideas.

After Sandford Jackson's visit to Europe he made many sweeping changes. One of these was to shorten the nurses' uniforms which were to be at least twelve inches from the ground. The outcry against this was very great as the nurses thought the style of dress far too advanced. They felt that their extremities should not be demonstrated in this fashion and such a sacrifice of the maidenly virtues was too great even for the altar of asepis.

As a final example of the similar viewpoint, Sandford Jackson's delightful explanation of the night cap used in early days is worth quoting. He points out "there was no provision for mosquito nets at the hospital, although it stood on the bank of the river. This was where the night caps came in. With the caps pulled well down over the nose and the hands placed under the blankets the mosquitoes could almost be ignored. When any of the prisoners escaped from hospital, as they often did, they took with them their night caps." Faced with such a contingency, would not our reaction be identical? We, too, would cherish our night caps!

#### History and War.

Man is largely a "tabloid" thinker. He adopts an idea, puts it into a frame and keeps it there long after the frame is out of date. History is in this category, for, to many, it recalls the portrait of an old fellow with white whiskers, poring over a dusty book. For both picture and frame, we are indebted to the old-time pedagogy which satiated us with such a fare of warped history as to produce mental indigestion. This outlook is so ingrained in the mind of many, that perhaps it would be wise to rename history and call it "the study of recurrence". Is not history largely the story of "events which recur"? The essential fabric of man is identical through the ages. Cycles recur, passions come and go, slumps succeed depression, complacency ushers in decline. There is a vital example today.

The psychiatrist is facing a situation for which there is an abundance of historical parallels. The war is commencing its harvest of neurotics and psychotics produced, or perhaps we might say more correctly, revealed through the war machine. Shortly after 1918, the war office in England produced a magnificent report on the problem of nervous disease and military service. It pointed out, for future generations, both pitfalls and treatment. The book is small, terse and interesting. It should be read by all medical men who have to deal with soldiers, yet such is our neglect of the historical angle, it is doubtful whether half a dozen copies would be found in the length and breadth of Queensland.

As a result of our neglect to realize that man is fundamentally a nervous creature, whose nervousness is as much a part of his make-up as is the colour of his eyes or the texture of his skin, we stand the risk of treating many nervous soldiers as sufferers from a disease. To make matters worse, as in the last war, we may award pecuniary benefits which will hinder rather than help the cure.

Recently I published an account of "normal nervousness".<sup>(1)</sup> From the historical point of view it is interesting to note that it was present among some of our ancestors who left in the first fleet for Australia.

The whole study of medicine epitomizes this story of recurrence. Frequently from the knowledge of just one symptom, the doctor deduces the eventual end of a patient. Whilst the outsider sees a fantastic clue, the trained observer views certainties, since clinical history repeats itself. A type of anaesthesia unfolds leprosy, a chest pain indicates coronary occlusion, an hallucination reveals schizophrenia. Such observations are commonplace. We



do not realize their significance in a wider field. We do not suspect that they are equally true in a sociological sense.

#### History and Parliament.

Before the last war it was apparent to Lord Roberts that a conflict with Germany was inevitable. He was ridiculed. Before this war Churchill, the historian, spoke vividly concerning the inevitability of war. He, too, was ridiculed. Today his simple rules of "two and two making four" are obvious. Unfortunately, our statesmen, instead of being so historically minded as to consider seriously the importance of recurrence, were wedded to the fairy tale attitude of appeasement. In our parliaments we are used to the idea of folios for various objectives. A folio, or at least a department, of history would bestow many material advantages.

When the physician diagnoses a case and makes a prognosis, he draws on the bank of personal history for his information. Parliament needs a super historian, who by drawing on the bank of universal history can reach conclusions on practically every detail of social life. You will, of course, appreciate that I am not speaking of history as a collection of books, but rather as an organization to sift evidence and winnow the seeds of truth from the husks of coincidence.

#### Military Strategy and the Historian.

The historical point of view applies to every phase of war activity. One has been feeling that many soldiers have to their disadvantage forgotten the exploits of our own great generals. There is much talk of "Blitz" methods. German names are thereby adopted to manoeuvres for which the Hun is not actually responsible. This is bad propaganda.

Napoleon, when meditating at St. Helena, said: "Let my son be taught history. It is the only true philosophy and the only true psychology." I have been surprised to find soldiers who have no knowledge of the battles fought by Marlborough. It is an astonishing admission, in view of the easy accessibility of accounts such as that of Maurice Ashley.<sup>(1)</sup> Our detractors say that the English have few military talents, yet this great Englishman was one of the military geniuses of all time. In his campaigns we see the use of many "so-called" modern innovations. He realized the value of fire power and held positions lightly, so that he could throw in preponderating forces elsewhere. He anticipated geopolitics by viewing the campaign as a wide military, social and political manoeuvre and not as an individual battle.

His man mastery was remarkable and showed a deep psychological insight into the minds of subordinates. Marlborough used infinite pains in choosing his officers and made a close study of military weapons. He exploited new ideas—for instance, the use of a ring bayonet which transformed pikemen into riflemen.

It has taken us years to become "attack" minded. Marlborough laid down "offence" as one of his first principles. He used every ruse where he might surprise his enemy. The value of "distraction" was employed as being one of the greatest military weapons.

The exact personnel of our military high command is, of course, a closely guarded secret. One hopes that when the grand strategy is being prepared, an historian will be included. From knowledge of previous military campaigns it would be possible for him to deduce a wealth of relevant material. It is not suggested that the historian will act in the executive capacity—his value is as an adviser.

#### Every Civilian Needs History.

Lack of the historical perspective makes our civilians fall into many errors. They are too fearful of tomorrow. They hang on words—they perpetually seek for signs. The report of one good battle cheers them inordinately, whereas a reverse puts them into the depths of despair. Such an attitude leads to the destruction of morale. Were citizens historically minded, they would realize that reverses do not necessarily mean an eventual enemy victory—also that victory does not come overnight. The historian looks to the broad plan rather than to the narrow front.

Again using a medical analogy, Mr. Manstreet too frequently makes a prognosis on the strength of a symptom rather than on the underlying metabolic process. Clinical acumen is based on the physician's memory of past cases. This enables him to look ahead. In the same way the history of world events enables the citizen to look into the future.

Is it not true that often we are appalled at the horrors of war? Humanitarianism tends to produce timidity, instead of that ruthlessness which brings victory. The history of peace gives a truer perspective. It recalls the thousands killed annually by motors in our streets or the countless thousands killed by epidemics of influenza and other scourges. Such tragedies are regarded with neither wonder nor amazement. History tells us that more will die of disease than of wounds. The majority, in spite of war, will die in their beds. History is emphatic that in war ruthlessness pays big dividends.

History shows us the tragic fate of endless causes ruined by selfish interests which refuse cooperation. It demonstrates the extraordinary successes which follow whole-hearted enterprise and enthusiasm even against the greatest odds. It does not show us the great achievements of the complacent and lazy, for the simple reason that, faced with barbarous fanaticism, they always fight a losing battle.

#### History and the Fate of Civilization.

Few will deny the greatness of Gibbon as an historian. He spent many years of research on the causes of the decline and fall of the Roman Empire. We find him in 1780 drawing certain conclusions based on history.

Gibbon writes:

The savage nations of the globe are the common enemies of civilized society; and we may inquire with anxious curiosity whether Europe is still threatened with a repetition of those calamities which formerly oppressed the arms and institutions of Rome. Perhaps the same reflections will illustrate the fall of that mighty Empire and explain the probable causes of our actual security.

Cold, poverty, and a life of danger and fatigue fortify the strength and courage of Barbarians. In every age they have oppressed the polite and peaceful nations of China, India and Persia, who neglected, and still neglect, to counterbalance these natural powers by the resources of military art. The warlike states of antiquity, Greece, Macedonia, and Rome, educated a race of soldiers; exercised their bodies, disciplined their courage, multiplied their forces by regular evolutions, and converted the iron which they possessed into strong and serviceable weapons. But this superiority insensibly declined with their laws and manners; and the feeble policy of Constantine and his successors armed and instructed, for the ruin of the Empire, the rude valour of the Barbarian mercenaries.

Could these words be etched into the minds of our civilians together with the realization that our civilization is in as grave a predicament as that which faced Rome, then the war effort would be magnified enormously.

History with no uncertain voice tells us that we must spur ourselves to the highest possible pitch, otherwise truly—"God help us".

#### The Prophylaxis of War.

If a man kills his neighbour he is placed in prison and receives a life sentence. If by chance he succeeds in repeating the offence in all probability he will be taken to the psychiatrist as suffering from a disease. From the earliest recorded times, man has tended to settle his group differences by the mass murder known as war. Our forefathers thought it normal. We are beginning to see in recurring wars the result of sociological disease. We are now realizing that war is a medical problem. There is in fact a dissociation of the psychic make-up which leads to the outlet of excessive and ill-regulated aggressive tendencies. The masses are unable to sublimate their urges.

Every disease has its prophylactic angle; indeed the modern tendency is to exalt prophylaxis as the most important line of treatment. This is the case in individual behaviour problems. Today, most psychiatrists realize that

the schizoid and the hysteric must be "caught early". The aim is prophylaxis in childhood before dissociation has taken place.

Let me cite a parallel. One of the claims to fame possessed by the Brisbane General Hospital is its historic treatment of typhoid fever. Baths were provided in which the patient might recline for hours or days. Whilst this treatment was admirable, its efficacy cannot be compared with that of preventing the onset of typhoid fever through inoculation.

War is in a similar category. Whilst we admire to the full the devotion of our soldiers, sailors and airmen who give their lives to save civilization, it would have been wiser if our statesmen had made war impossible by diagnosing the cause, and correctly harnessing those aggressive impulses which in themselves are not harmful, since they provide a large proportion of the driving urges of our civilization.

As medical men we are used to new remedies. Time is required for their acceptance. The pioneer meets the resistance of mass neophobia which has already been mentioned.

#### Coalescence is the Key.

Some years ago Dr. Jarvis Nye and myself in "Whither Away" made a prophecy concerning the probability that war would occur in a comparatively short time. Unfortunately the prophecy has been abundantly justified. Whilst the role of prophet is notoriously insecure, we were bold enough to suggest in a sequel "The Way Out" that the prophylaxis of war had been discovered through the genius of an American, Clarence K. Streit, author of "Union Now". Those who doubt the force of these contentions should study for a few hours the long successions of federations throughout history. Tribes coalesce into large communities. The federations soon acquire a new overriding sentiment for the union. In their turn the coalescing tribes become nations. For many reasons it would have been better if instead of using the word federal union or federation we had used the term coalescence.

Streit made his discovery largely through the study of history. In his book he traces the development of the United States of America. It commenced with the friendship of thirteen States on the verge of war. They distrusted each other, but achieved harmony through a remarkable document which is a milestone in the wake of human progress. I refer to the constitution of the United States of America. Instead of glorifying the nation, it outlines the rights of man. It emphasizes our inherent right to defence at law, and insists on the equality of the citizen. Fortunately, this great charter is not unique. There is no need to stake our future on one event, nor to follow a solitary clue blindly to its conclusion. History permits the view of other examples of federation. Everywhere it creates unity in the place of chaos. Great Britain itself bases its greatness on the use of federal principles, which coalesced the English, the Scottish and the Welsh peoples. There are working federations in Switzerland, in South Africa and in the great Union of Socialist Soviet Republics. It so happens that Australians have the opportunity of understanding federation or coalescence extremely well since our constitution is based on the American model.

In "The Way Out" we wrote:

Causes and results of all destructive wars are always the same. They owe their birth to desire and greed on the part of a few power-seekers in certain nations; and by a process of psychological transmutation, there is soon brought about a virulent international infection of hysteria and hatred. Only after years of struggles, hardships and death of millions does the voice of reason reach the ears of the common man. Its voice is always the same.

Why did we destroy so much happiness and so many of our best lives for objectives which could have been secured by reasoning and unselfish planning? When great nations go to war, the costs and results are incalculable, yet we read the old, old story which has been repeated a hundred times in the history of mankind—nations of similar culture and types fighting to the death for non-essentials, thereby providing a glorious opportunity for the invader from another quarter.

The Way Out depends on ourselves. To-day the same problems and the same fate which confronted Egypt, Babylon, Greece and Rome confront us.

As Alexis Carrel has so aptly said:

For the first time in the history of humanity a crumbling civilization is capable of discerning the cause of its decay. For the first time it has at its disposal the gigantic strength of science. Will we utilize this knowledge and this power? It is our only hope of escaping the common fate of all great civilizations of the past. Our destination is in our own hands. On the new road we must go forward.

This new road is Federal Union.

We do not retract these words. We add the alternative label of "coalescence". They are true today as of yesterday. They will be true tomorrow, but how long it will take humanity to learn wisdom is a secret known only to time. The reader must, of course, differentiate between the principle of coalescence and its practical application. Whilst agreeing with the principles enunciated by Streit, there will be legitimate discussion as to which nations should unite. It is considered that widespread coalescence in which the British Empire must participate will be an essential preliminary to permanent peace.

#### History and the Post-War Problem.

Most people are aware of the controversies concerning post-war reconstruction. The realist says: "Let us commence to plan now." The super-realist says: "The most important thing is to win the war. Let us plan for post-war reconstruction when the war is won." We all know the extrovert who cheerfully takes a watch to pieces and then finds it impossible to get it together again. He is the type of super-realist who plans only for the moment. Unfortunately the end does not enter into his calculation, he hopes, trusts and anticipates all will be well. When the watch remains a derelict, he is surprised, but still cheerful.

I feel sure that most historians belong to the realist type who believe we should plan now for victory in the future peace. History tells them that men fight better when they have an objective in view. The Germans and the Japanese are fighting to be kings of the universe. We are fighting for a better way of life, but we need a blue print to give objective proof that we are not fighting for a shadow, an illusion or a pious hope which will merely lead us to frustration. The historically minded will not ask for a peace plan of vengeance, since the record of mankind shows very clearly that the end of revenge is an endless chain of hate. They will demand justice.

As an essential preliminary for the new world of tomorrow we need a better adult education. Can we have this unless we pay far more attention to history and cease to pay lip service to science and knowledge. If asked for a caption which would describe our attitude to many problems of life prior to this present way, few will deny that of "lip service". We talked airily of truth and science—of beauty and harmony. In spite of the efforts of a few enthusiasts, there has been striving neither by the masses, nor by our statesmen to bring ideals from the category of "wishful thinking" into that of "reality thought".

#### The Pre-War Laissez-Faire.

Our city of Brisbane demonstrates the lack of a civic soul. We have an Historical Society. Its treasures are housed in an historic mansion at Newstead. It contains some 6,000 books, 5,000 pamphlets, 3,000 historical photographs and some historical relics. They are no longer in the public view. At the Oxley Library we have no less than 20,000 books, manuscripts, pamphlets and other objects of historic interest. These priceless treasures are housed in an inadequate Public Library and the intelligent observer will notice that the shelves and staircases are of wood. Inevitably if there was a fire in the building it would be an end to a large part of the historical material of Brisbane and Queensland.

The treasures so faithfully collected by Sandford Jackson are worthy of a central home in a fireproof building. It



may be mentioned that the Church of England Grammar School possess 160 of his original typescripts, manuscripts, maps and scrap books. Their titles alone are a recapitulation of early Queensland history.

The Royal Society which exists for the discussion and encouragement of science on a broad scale is through the generosity of the university housed in that institution. It has a library and must be included in the ambit of history. Thus three of the cultural institutions of Brisbane are housed in different buildings. The student must wend his way from building to building with the maximum of inconvenience and the minimum of efficiency. In addition to these there are many other societies of a cultural nature which are available not merely to the university student but also to that important individual—the average citizen. We may mention such organizations as the Geographical Society, the China Society, the Institute of International Affairs, the Constitutional Club, the Australian American Association, the New Education Fellowship, the Authors and Artists Association, the League of Nations Union, the Dickens Fellowship *et cetera*. Each has an historical background.

It can hardly be denied that if a central building were erected in Brisbane which would contain lecture rooms and library accommodation for the various societies which I have already mentioned, and others, it would be not merely a great convenience to those who are wishful to study, but also a stimulus to the spread of cultural knowledge. Admittedly such a scheme would cost money, but surely our greatest need after this war is over will be to find work for the thousands who are now engaged in the war effort. In fairness to our government, it must be conceded that prior to the war it had a definite plan for better library facilities under consideration. It is to be hoped that the project will be pushed forward with the greatest determination and the maximum cooperation between the cultural centres involved.

Let me now plead the cause of a somewhat different institution which should be housed in the same or an adjacent centre. Already we are acquainted with the advantages accruing from the natural history museum. This is visited by thousands of adults and children during each year and serves a very excellent educational purpose.

#### The Museum of Man and its Lease Lend Policy.

We need a museum of man, a museum of all the arts and the crafts which have existed since the beginning of our civilization. Such a type of historical enterprise would be of inestimable value. The student of every trade and profession would be able to see the beginnings of his craft. He would note the developments which occurred through the years and see them side by side with working models of the latest products. At such institutions as the Royal National Show we do from time to time see working models of the telephone system and the like. These receive the rapt attention of crowds. Is there any reason why there should not be a permanent building in which such activities may be shown? I personally regard the enjoyment of the museum facilities provided in London as being possibly the most important part of my general education. As a young student I had much pleasure and profit in making weekly visits to its numerous museums. It is certain that if we put our shoulder to the wheel we too could soon have a worthwhile museum of the arts and crafts.

The critic will ask where the large range of exhibits can be acquired. I must remind you that we are not speaking of a mere local undertaking. Post-war planning must be on a large scale. It must indeed be international. Every country in the world has some unique feature which is of interest to others. Why should there not be a "universal lease lend of historical material"? The making of the exhibits would occupy thousands of men and women, materials would be sent to every corner of the earth where they would clearly demonstrate the unity of man. Too many people have the idea that a museum is a junk house wherein dusty exhibits gradually fade away. The type of museum which we are considering is an active museum. Exhibits arrive and are sent to travel around the cities of our land. By this means we would in a State-wide sense

become acquainted not merely with our own arts but also with those of the wide world.

Without doubt other countries would be interested in our own special achievements. The growth of the merino sheep industry, opal mines, silver lead at Mount Isa, gold mines at Kalgoorlie, aboriginal history including the use of the boomerang—all would be headline museum attractions. After we had arranged our collection it would be a comparatively simple matter, through a clearing house, to arrange for their exchange in other countries. In this way with little expense we would have a continuous flow of interesting and valuable material. It would not be difficult for Australia to originate such a scheme.

I have been struck with the interest taken in feature films. It is fascinating to take part in a pictorial ascent of the Himalayas, to travel down the Amazon or to visit the magnificent scenes of Alaska. Such an interest would be stimulated if our museums would show us not merely the pictures, but also the actual handicrafts of the countries concerned.

I can conceive that in this "lend lease arrangement" we would receive not merely objects of interest, but also literature and films. Men and women would be sent as travelling showmen to demonstrate the wares which they would bring.

#### The Use of Local Museums.

I have spoken of museums in a broad sense and have suggested that they should be grouped around a civic centre. This project must not, however, be taken too literally. Some buildings have an historic significance. It is seemly that our historic society should be situated at Breakfast Creek, famed as the landing place of Lieutenant Oxley. This landmark should be preserved; indeed all old buildings of a permanent nature with each passing year possess an increasing historical value.

Tonight we honour the memory of our greatest medical historian, Sandford Jackson. I can think of no better method of doing so than by suggesting that the case books of the Moreton Bay Hospital which he regarded with such affection should be housed in an historic building which is still present in the grounds of the Brisbane General Hospital. I refer to the residence of the first medical superintendent which was built in 1866 by the famous pioneer John Petrie, and was subsequently used by Sandford Jackson as his own residence. The house is an architectural gem worthy of retention on artistic grounds. Future architects will see in it a good example of colonial building methods. The staircase alone does credit to the craftsmen of its day and warrants its immunity from demolition. Within its walls we might not merely keep our priceless medical records, but also show exhibits illustrating the evolution of medicine from early colonial days. It would help our students to get a background of history if they could see exactly the nature of the tools, the dress, the furniture, and the medicines of a surgeon in the early part of the last century.

If we do not wait too long before commencing such an undertaking it should be possible to obtain the material, but each year the difficulties become greater. The time to commence is now. Without doubt, were this museum in existence it would be the Mecca of every doctor who visited our metropolis. The last few years have seen an extraordinary change in the methods of medicine which is worthy of practical recognition. In addition to an 1850 exhibit there is place for an historical survey of the "A.R.P." public health measures and therapeutic advances of the last decade. It would be interesting to label the contents of one room "Circa Great War of 1939". In this connexion may I remind our medical leaders, and with them I couple the name of the Minister for Health and Home Affairs, the Honourable E. M. Hanlon, that those who initiate great activities should record them in a suitable manner. We men and women of today are the torch-bearers for posterity. It is our duty to see that the "brown out" and the "black out" do not apply to history.

So far we have dealt with historical museums on a cultural plane. It must not be forgotten, however, that these have a very definite practical social value. They are

magnets which will draw tourists from every end of the world, and it must be recollected that tourist traffic is a major industry.

Those who have patiently borne with me through this brief survey may consider that I already have envisaged ambitious schemes. Actually I have the feeling that were Sandford Jackson present tonight he would say: "Is that all? Surely you have forgotten two most important projects which lie ahead."

The first has been frequently mentioned. There is urgent need for new public libraries throughout Queensland. We have an unenviable record of criticism of our lack of libraries. The treasures of our Brisbane Public Library are housed in an inadequate building which lacks the facilities of an institution on modern lines. Furthermore our children need their own public library or at least a wing of the main building.

#### Need for Further Social Measures.

Let us label the second phase of our activity the "further prophylaxis against future wars". I feel certain that Sandford Jackson would ask whether we could not find from history further clues for the outlawing of war. I have already mentioned the possibility of coalescence in which the individual rather than the nation becomes the dominating factor. This is an insurance against the possibility that a few men who happen to be in power can drive the nation to its destruction. Undoubtedly such a form of organization has great strength, partly because, as I have pointed out elsewhere,<sup>(1)</sup> there is produced an overriding sentiment which transcends previous national boundaries. It would not be long before the sentiment for the united nations became even stronger than the sentiment which today exists for the federation of our own Australian States. But we cannot afford to leave matters to chance. We must use every method at our disposal in order to create the new ideal of citizenship in which law and order govern international relationship instead of that anarchy which we know as war.

#### Educate Early and Efficiently.

It may be said that every great religious teacher insists that doctrines must be taught at an early age. The child at the mother's knees learns those first lessons of conduct which will carry it through life. The history of the last twenty years shows a new application of this ancient psychological principle. Hitler, Mussolini, and the Japanese leaders have set out to fill the mind of their young countrymen with a burning belief of their own invincibility and the goal of the new world order in which they hope to be supreme. We must admit that they have had great success in creating a morale which, had it been devoted to better ends, could have been universally admired. They have actually taught their youth that death for the fatherland is a worthwhile virtue, and we have the spectacle of their soldiers indulging enthusiastically in a type of warfare which even to the victor is little better than mass suicide.

#### On Changing Child Psychology.

The technique of such training is essentially simple. It consists in influencing the child's mind at the earliest possible age by teaching, by action, by examples, by films, by radio, by mass meetings—in fact by every conceivable avenue for suggestion and persuasion, imitation and play. The whole child life is planned to the last detail. Nothing is left to chance. No item is too small for consideration.

As already indicated, history shows us that the psychology of man may be altered through education. If wars are to cease, we cannot neglect this great opportunity for teaching a new conception of the brotherhood of man and the inviolability of his rights. As I have already pointed out, there is a vast history of methods employed for the influencing of youth. In our children we must sow the seeds of a belief of a new order of human brotherhood. It has to be done consistently, forcibly, energetically, realistically on a thirty-year plan. It would be fatal to stay these activities even for a year. We need the driving

force of an Ignatius vowed to the service of the whole of humanity.

I trust you will not consider that I am a dreamer who spins phantasies in moments of wishful thinking. A civil engineer who sees in his mind a vast undertaking may be completely certain of its success because he realizes the true values of iron and concrete. I speak as a psychologist who understands the realities of the herd instincts. Compared to the job of building Sydney Harbour Bridge or a battleship, our task is comparatively simple. The chief difficulty is long-range statesmanship on an international plane to enable us to create the necessary machine.

Let me outline some of the steps. In order to get our perspective right, it must be realized that we are speaking of a world organization as part of a peace plan.

#### Six Essential Steps.

Firstly, every history book used by children must be revised. Kings and queens must step from their pedestal and give place to the army of public benefactors whose life has been an inspiration. Instead of children being taught long lists of battles and wars they will be taught the real battles of human progress.

Every nation can supply its quota of great men. The child of the future will be spared the disaster of having to regard history as the story of mere selfish barbarians who regarded war as a legitimate means of satisfying greed. At last humanity has the chance of learning the names of its real heroes. Children will be taught to respect those who work for public good, and to despise the tyrant, the exploiter and the wastrel. Their education must commence in the kindergarten, which we trust will be universal. As I. H. Robinson says in "The Human Comedy", we need a new type of history teacher, "a wonderer and pointer-out whose curiosity shall be excited by this strange and perturbing emergency in which we find ourselves, and who shall set himself to discover and indicate to his busy and timid fellow creatures, a possible way out".

Secondly, short-wave wireless must be harnessed so that world history may be given by other nationals from overseas. The use of a common language for such broadcast will go far to overcome difficulties of speech. Considerable work has been done on the nature of a common tongue. There is much to be said for Basic English which entails a vocabulary of a mere 850 words. The basic language of whatever form is adopted will be employed in an international school journal having a world coverage.

Thirdly, there will be a regular exchange of school teachers. Our teachers will go to Europe, to America, to China, to Russia, to India, to Ecuador. We will receive their teachers in return. Such a periodic exchange will have many advantages. It will go far to break down the insularity of the teaching profession and provide a new stimulus. Through the medium of travel, education will be a more popular occupation. It need hardly be stressed that anything which uplifts the teaching profession will have a beneficial effect on the pupils. This exchange of teachers is, of course, not an innovation. At first sight, it might appear that the cost would be too great, but we must remember that the chief additional expense is that of transport—the wages are unaltered.

Fourthly, selected scholars will go overseas by an exchange plan similar to that for teachers. There will be a considerable extension of such movements as that of the Young Australia League whereby scholars will travel overseas during their holidays in order to learn world history at first hand.

Fifthly, teaching must be practical. I have already visualized the widespread use of cultural museums with travelling displays. Such facilities would be linked up with the teaching of school children and would provide not the least important means of creating the ideas and ideals of world citizenship and brotherliness.

Sixthly, the Press will be subsidized to give regular features illustrating international friendliness. An



organization of the magnitude we have described will provide a wealth of interesting material. There will be an international school journal.

#### Conclusion.

In conclusion I wish to make a last reference to Sandford Jackson. I have presumed that he would view with approbation all means of diffusing a wider knowledge of history. We can be certain that he would appreciate the need for harnessing the sinews of war to the problems of peace. Few people have the physician's opportunity of seeing at first hand the results of social economics. To him the breadline has a very real meaning. He sees the horrors of poverty and the trail of misery which is present in every cycle of depression. Work must be found for these teeming millions who though at present employed in the war machine will be workless at the armistice. The cost will run into fabulous amounts, but we are being newly orientated to the flow of filthy lucre. Economists tell us that money can be pumped to satisfy all needs. If this be true, and experience certainly points to its reality, let us as historians insist that the post-war planning be done on a priority basis. If our cardinal need is to prevent future wars, are we wrong in asking that history will be number 1 priority? Would it not in the long run be more profitable to build world conviction of international friendliness than to devote all our labours to work which may show a utilitarian return in mere financial dividends? In the last analysis, would not the certainty of world peace in the minds of the next generation pay an even more staggering dividend at the bank of human happiness?

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### VARICOSE VEINS IN PEACE AND WAR.

By C. H. W. LAWES,

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VARICOSE VEINS are not very exciting things; in fact they fall into quite another class. One likes to forget them, pretend they do not exist as a cause of suffering and disability—a pretence that is shattered when one is confronted with a varicose vein clinic. These clinics are a necessary evil of all big hospitals, but they are depressing places that suggest fat dirty people and horrible smells.

Nor are they exciting for the poor unfortunate people that have them. She—generally she—suffers a great deal, and they are poor topics of "complaint" conversation. She may attain some status with the next door neighbour who suffers from an ingrowing toenail, but she must eat humble pie before the woman who can produce a bottle of gallstones, or who can say that the doctor said she was a most interesting case. But she suffers more than these others, and it is not only physical pain. Her legs are unsightly, either fat or oedematous and shapeless or nobbly and bumpy. Her dermatitis weeps continuously, she has to find a constant supply of bandages, and in the bathroom cupboard is an assortment of cures, which have been hopefully and uselessly tried. Her ulcer is messy and painful, so that she does not go out. Her whole life revolves round the cleaning and dressing of her leg. This is a gloomy picture, but unfortunately a true one, for the varicose vein is a depressing and degrading thing.

Let us look at the hospital's attitude. Here, the varicose vein is the humblest and lowliest case. Certainly, such cases are banded together and given the name of "clinic". There are many clinics: diabetic clinics, fracture clinics, neurological clinics, and so on. Here are interesting cases

seen by the leaders in each branch of medicine and surgery, who also organize and direct the work, standardize methods and teach. But this is not so with the varicose vein clinic. No surgeon ever goes near it. The assistant surgeon may see some of the cases, but the clinic is run generally by a resident medical officer—the more junior the better, for he cannot pass it on to anybody else. He struggles with it valiantly and continuously for a few months. He gives countless injections to an endless stream of patients, whose thick bundle of out-patient papers bears evidence of valiant and similarly unavailing efforts of previously harassed resident medical officers. And then look at the ulcers and dermatitis cases. They are not admitted to the "clinic". They belong to the dermatologist. He is faced with a swarm of patients—an unfortunate, evil smelling group of sufferers, huddled in a room with remnants of Unna's paste and "Elasto", scattered about. Maybe he gives a quick look, and away to his clean office to smoke a cigarette and write "Rep" on the corresponding swarm of cards, and so on to his skin cases. It is all very strange. The ulcer and the dermatitis are the results of the varicose veins, and it would seem natural to put all under the care of the surgeon. But the old principle of "pass it on" holds very strongly here. It is bad enough for the surgeon to have such things as varicose veins put under his care, and it is too much to expect him to suffer the indignity of ulcers also.

What has been responsible for this neglect of the varicose vein patient, and for his or her dual control treatment? There are two reasons: (i) lack of glamour in the varicose vein case, (ii) inability of the surgeon to achieve any striking results.

Many surgeons like to do big operations—operations on goitres and breasts, operations in abdominal conditions, gastrectomies and so on. Such operations are not everyday affairs for the surgeon, and are foemen worthy of their steel. There is a certain glamour about them, and doubtless a justifiable thrill and feeling of satisfaction for the surgeon in doing a difficult and long operation successfully. Varicose veins have no such appeal. There is no credit in running a varicose vein clinic; no establishment of reputation in strapping ulcers; no admiring audiences during the application of Unna's paste, and so the varicose vein is not of interest to the surgeon, who leaves such things to his assistant, who relegates them to the resident medical officer and the dermatologist.

There is a hopelessness about the varicose vein clinic. Nothing is more discouraging than to find that accepted methods do no good, and the futility of repeated injections for the majority of varicose vein cases is well seen in any clinic. So the resident medical officer struggles on, and knows that soon his turn will be over, and then he will forget such things. But the poor dermatologist and out-patient sister go on signing cards and applying "Elastos".

Varicose veins are small dull fish surgically, but they are very big fish to the unfortunate patient. What is the outlook, and what is the remedy? The new ligation treatment promises to raise the standards of results, and so the status of the varicose vein cases. This will not happen until varicose veins are recognized as a class of condition needing earnest consideration and a highly organized and well-controlled clinic, supervised by a surgeon who is not only interested in such work, but skilful and experienced in all its branches. All these patients can be cured, but not whilst the present attitude towards them persists.

#### Varicose Veins and the Army.

The civilian attitude being what it is, it is not to be expected that the military attitude will be any different. Nor is it so. The most important part of the soldier's body is the leg. Bad legs mean bad soldiers. This is elementary, but there is a time-honoured dictum, that an army marches on its stomach. This would seem to be accepted, for the neglect and nonchalance shown in civil life towards varicose veins are repeated in the army. It is interesting to trace the varicose vein patient's career in the army, and work done in clinics in Sydney before enlistment, in camp hospitals in New South Wales, in clinics again in the Middle East, make a continuous story. The end of the

story, as far as this war is concerned, cannot be told yet, but it is instructive to study results of varicose veins in the last war. This has been possible through work done and patients seen in a repatriation hospital. These old cases make it possible to predict accurately the final stages of the present patient's career, and to make some concrete proposals for dealing with the situation.

#### At Enlistment.

In early days of the war, there was an enrolling office in the city. Many men were rejected because of varicose veins, and told to have treatment and return for further examination. Many of these men came from the country and appeared in large numbers at hospital. A majority of cases were severe and needed ligation and retrograde injection. Here was the first problem. No beds were available. Beds for patients with varicose veins were an unheard of thing, when this specialist had only a few beds, and that one wanted more, and so on. The fact that these were otherwise healthy men, eager to join the army which needed them so badly, could not overcome peace-time customs. So no beds were available.

There were two results: (a) Men with very severe varicose veins went home, and generally stayed there. (b) Those whose condition was less severe were given injections, either in the orthodox fashion or in the ingenious method described by Gill (1941). These men were returned to the depot, proudly displaying thromboses, and were accepted. In these cases the varicose condition will inevitably recur. Unlike men in the first group, they are not lost to the army, for they will cling to its hospitals for many a day, and even after the war, unless more care is taken of them. The view of the military authorities was that, until passed as medically fit, these men were not the army's responsibility. This is a sound view theoretically, but why accept such men after indifferent treatment? They then do become the army's responsibility, and are more difficult to deal with. So it is that at the beginning of a soldier's career his varicose veins are given makeshift attention, with no effort to set out standards of severity, treatment or cure.

#### In Camp in Australia.

Many men with varicose veins were seen in camp in Australia. In the camp dressing stations surgical consultations were held, and men with varicose veins were constantly being referred by regimental medical officers for treatment. In quite a number of these cases ligation was needed, and in a country camp, where the local hospital was available for surgery, saphenous ligation was a constant operation, and appeared on most operating lists. It is interesting to note that these operations were done on soldiers who had been in camp for a matter of months only.

#### In the Middle East.

The varicose vein clinic is a feature of the general hospitals in the Middle East. At one Australian general hospital alone, the number of cases seen was about 500 in eighteen months, and of these 60 only were seen in the first six months, and many saphenous ligations have been done. But alas, in these hospitals the clinic gets little respect and arouses no enthusiasm. The civilian attitude persists. The clinic is unpopular. It provides a hard afternoon's work, for it is generally coupled with the so-called haemorrhoid clinic, and the rectum is another weak spot in the soldier of today. So the combined clinic is a large one, and it is often "done" in turn by the various medical officers, generally by the captains, as there are no lieutenants in the Australian Army Medical Corps. The problem at this stage is not an easy one. Units move from place to place, and medical officers also move. Supplies are difficult to obtain, and transport difficulties arise. Continuity of treatment, a very important item in the treatment of varicose veins, is difficult to obtain. Regular clinics are secondary in importance to war casualties. The process of cure now is more complicated, but at the outset of the soldier's military career it is simple.

**Type of Cases Seen.**—Some cases were very mild, not constituting a disability at all. In others, also mild, a few injections were needed. But there are a large number of men with varicose veins of severe type needing operation, and some of these show extensive and large bunches. In at least 60% of the new cases seen the patients need operation.

Why are there so many cases? There are three reasons. The varicose veins (a) are present on enlistment, (b) occur after enlistment, (c) recur after treatment.

In regard to varicose veins present on enlistment, the questioning of soldiers has brought forth some illuminating replies. Many soldiers admit the veins were present on enlistment. They were not rejected because: (i) The examining officer did not see them, either through not looking, or through not seeing though looking. (ii) The examining officer saw them, and said they were not severe enough to worry about. The wisdom of this advice is suspect, in view of the life a soldier must lead; in view of the number of cases seen in the Middle East; and in view of one soldier's remark, that he rested the day before his medical examination, and arriving early on the day, sat with his legs up prior to going before the medical officer.

In regard to varicose veins occurring after enlistment, only a clairvoyant, an astrologer or a herbalist can predict the future accurately, and as our profession disapproves of such sciences, cases in this class must be accepted as inevitable.

In regard to recurrence after enlistment, this is a common class. Many patients seen have had treatment of all sorts. Injections, of course, head the list. Some injections would seem to have been incompletely done, doubtless owing to haste of the patient to enlist; and the recurrence rate is probably higher than in civilian life and recurrence is earlier, as the patients are soldiers. Imperfectly performed saphenous ligatures have been seen, common faults being incorrect placing of ligations, failure to divide superficial branches at the *fossa ovalis*, and incorrect retrograde injections. And there is the good old friend, local excision of varix, with very early recurrence.

#### Repatriation Problems.

Repatriation problems can be predicted from a combined study of the approach to the problem during the soldier's life as detailed above, and the results of treatment during and after the last war. Anyone who has worked in a repatriation hospital will have been impressed with the difficulty of the varicose vein problem. Even now, twenty-three years after the last war, many patients with a vast array of fearsome varicose veins are to be seen; they have enormous files of papers, and have had colossal amounts of treatment. The cause is the same, namely, incorrect treatment, that is, judged by modern standards of knowledge. It was not considered incorrect in the years during and after the last war, for only two methods of treatment were practised, namely, injection and excision, the Trendelenburg operation being temporarily in disfavour and forgotten. Results were not good. A new method has been evolved in the last seven or eight years, and it gives good results when it is correctly applied. So far this has not been appreciated either at home or abroad and has not been carried out, partly from lack of facilities, partly from lack of knowledge, enthusiasm and encouragement. The outlook for the future is clear. Many men with varicose veins will appear among repatriation patients. They will go on appearing twenty-three years after the end of this war, unless the importance of the condition and the necessity for its correct treatment are realized.

#### Suggestions.

##### At Enlistment.

The greatest care must be taken at the original examination. It is dangerous to pass a man as fit because varicose veins are not severe. Many such varicosities have developed to a surprising degree under the stress of active service conditions. Particularly is this so in younger men with



congenital type of varicose veins, and generally long thickened veins in the thigh, with bunches of small varicosities in the leg. These are not very obvious, though the vein is readily palpable in the thigh, nor do they appear severe, but they very rapidly become troublesome when extra strain is put upon them.

Some standards must be established. A rough classification into two classes is simply made. It is: (i) those who do not give the Trendelenburg reaction and (ii) those who do react to the Trendelenburg test. Men in class (i) could be accepted after properly performed injection therapy. Men in class (ii) should not be accepted until a high saphenous ligation has been performed. This is not the be-all and end-all in the treatment of these men, but merely the essential starting point. Further steps will depend on the conditions present in each case. This simple classification would do much to clarify the situation, but would not be entirely satisfactory. The treatment would vary with the knowledge, skill and views of the individual general practitioner, surgeon or physician in charge of the patient. Results would be variable and standards impossible.

The only solution is for the army to accept these men, classify them, and undertake their treatment at a central properly conducted clinic. It is far better to accept them and to provide correct treatment than to accept them after incorrect treatment. But a word of warning must be spoken of the danger of the civilian attitude pervading this army clinic. The let-us-get-this-unpleasant-afternoon's-work-over-quickly attitude persists with regard to varicose veins, and while it does, results will be bad.

#### Abroad.

The use of sound methods in Australia would reduce the problem to insignificance. At present it is the reverse, and large clinics are held. The remedy is the same, that is, properly controlled clinics, and the abolition of the old civilian outlook, alas, firmly rooted. The difficulties of treatment abroad have been mentioned. There should be little need for such treatment.

#### Repatriation.

Let us remember the twenty-three years of treatment after the last war for some varicose vein patients. There will be large numbers of cases after this war, and the final responsibility will rest with the Repatriation Department and its hospitals. They must decide between simple efficient methods properly applied and inefficient makeshift methods with years and years of treatment. Why is it that recurring conditions are treated so lightly and regarded as beneath one's dignity? Hernias are readily handed on, and just as readily recur. Varicose veins are almost an insult to the surgeon. But they are like the tortoise in the famous race—subdued for a time, but reappearing again—and twenty-three years is a long time for a disease to drag on. Surely it is worthy of everyone's earnest attention and thought. The fundamental facts are simple. Correctly planned and executed treatment will cure this disease. No other treatment will do so, and this applies particularly to haphazard methods, be they injection or operation or both.

#### Summary.

1. The present attitude towards varicose veins in civilian life is described.
2. Experiences of varicose vein patients are mapped out (a) at enlistment, (b) in camp, (c) abroad.
3. Predictions are made of repatriation problems.
4. Suggestions are put forward for improving conditions of examination and treatment.

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## Reports of Cases.

### A CASE OF DRUG ALLERGY OF BOTH TYPES: FIXED AND GENERALIZED ERUPTION.

By F. GOLDSCHLAG,  
Sydney.

THE term "drug eruption" denotes that the particular allergic skin symptoms are produced by a drug. The origin and clinical character of cutaneous lesions are independent of pharmacological and toxicological properties of the drug. Identical clinical pictures are produced by entirely unrelated drugs, and different types of skin manifestations in different subjects are produced by the same drug. There is unanimity of opinion that some simple chemicals to which drugs belong can act in a similar way as the living allergens—living microorganisms and their products—and give rise to specific sensitization. It must, however, be admitted that the existence of specific reagins and the passive transfer of antibodies in the case of drug eruptions have not yet been satisfactorily demonstrated. Moreover, the results of patch tests, with a few exceptions, are not conclusive in proving that a drug is the causal allergic agent.

The skin manifestations are of great variety. Eczematous lesions, multiform erythema, urticaria, morbilliform and scarlatiniform eruptions, pemphigoid or vegetating eruptions and many other forms may be present. One form first described by L. Brocq as "fixed" eruption deserves to be distinguished from other types. It appears, after the administration of a drug, as single urticarial erythematous or bullous patches in various areas in some patients who on previous occasions tolerated the drug well for a longer or shorter period. Once it has occurred, it reappears as a result of further administration of the drug on the exact site occupied by the patches in the first outbreak. The healing process ends often with pigmentation, which flares up and causes a sensation of burning or itching when the drug allergen comes into action again. Only the primarily affected areas, not the whole skin, seem to be sensitized. The eruption itself is of transitory character, and the term "fixed" is attributed rather to the selected skin islands which are in constant alertness and react promptly to any renewed attack of the drug.

A case which represents both types of drug eruption, fixed and generalized, seems worthy of publication.

#### Clinical Record.

G.S., aged sixty-four years, a manufacturer, had suffered from a tinea eruption on both palms for several years. He was being treated with ointments and X rays. Five years ago he first had some heart trouble. He has often been examined, and different opinions have been expressed about the nature of the condition. The last report pointed to pulmonary emphysema and extrasystoles without structural changes of the myocardium. The cardiograph revealed no abnormality.

A few months ago the administration of quinidine, 0.03 gramme three times a day, was instituted. Soon after that the patient noticed that his hands became swollen, dry, scaling, itching and strangely coloured. The swelling spread to the neck and to some parts of his face. At the end of May, 1942, he was taken ill with influenza, and powders containing phenacetin, aspirin and quinine hydrochloride were prescribed. The patient was under this treatment for three days, refraining during the influenza period from taking quinidine. Six days later, after fresh ingestion of quinidine, the swelling of the hands, neck and face became very pronounced and the itching distressing. An injection of adrenaline provided no relief. Quinidine was discarded, but nevertheless a rash appeared on the trunk.

At this time I first saw the patient. He presented a sharply demarcated, oedematous swelling of the dorsum of each hand, of the neck extending to the posterior border of the sternocleidomastoid muscle, of the forehead, of the temples and of part of the cheeks. Scaling, crusting and oozing were obvious in places. The most striking feature of the condition was its dusky, violaceous, rather unusual colour. Over the trunk, particularly on both sides, an acute scarlatiniform rash was discernible.

A diagnosis of generalized drug eruption was made, the condition on the hands, the neck and the face being first considered a different type of dermatosis. The patient was advised to avoid any drug, and a few injections of sodium thiosulphate were administered. An inert ointment was applied to the hands and face. The rash on the body disappeared within a week and the quick diminution in the "eczematous" condition was remarkable.

About a fortnight later the patient felt some irregularity of his heart's action. He took at 2 p.m. a quinidine powder, contrary to my advice. At 4 p.m. an unbearable itch developed on the hands, face and neck, slowly turning to a severe burning sensation. At 6 p.m. the patient noticed a swelling of the above-mentioned areas. At 11 p.m. he felt ill, and had shivering and vomiting attacks which lasted till 6 a.m. Next day a rash reappeared on the body. I saw the patient about twenty-four hours after the ingestion of quinidine. The previously described areas on the hands, neck and face were swollen and hot. The dusky, violaceous colour was present again. The scarlatiniform rash occupied the torso and limbs; its acute character was accentuated by hemorrhagic components in some lesions. The patient complained of burning and itching on the chest and back.

Because of associated heart sensations and some restlessness calcium bromide was injected and the intake of any other medicine was prohibited. The patient recovered quickly; the rash and other cutaneous symptoms disappeared entirely except on the hands, which remained visibly affected.

On July 21 the patient took a two-grain tablet of phenobarbital on retiring. He felt some itching on the hands during the night. Next morning he noticed some fresh crops of clear bullae, each the size of pea, on the dorsal parts of the hands. The bases of the lesions were bluish-red and the bullae were tense. They burst within the next two days, so that five days later I could see only what remained of the eruption. The patient was ordered to refrain from this drug until the eruption had disappeared entirely. Then the drug was to be taken again.

#### Comment.

It seems justifiable to assume that the "eczematous" reaction on the hands, neck and face was a particular response of these sensitized areas to a quinine compound, which was taken for a longer period in the form of quinidine and for a few days as quinine hydrochloride. Scaling, crusting and oozing were to some degree compatible with the diagnosis of eczema. The involvement of the hands and face—that is, the exposed parts of the body—might suggest an eczematous contact type of dermatitis due perhaps to an external, chemical agent; but the occupation of the patient and the history did not support this diagnosis. A strikingly sharp demarcation, a quite uncommon dusky and violaceous colour and the presence of an urticarial oedema aroused suspicion of a fixed drug eruption. The diagnosis was ascertained when the cessation of ingestion of the drug was followed by a quick improvement and the subsequent administration of a small amount of the drug led to an erysipelas-like flare-up of the primarily affected areas.

An interesting and infrequently observed feature of this case, in which the allergic manifestations were first restricted to the fixed type of eruption, was the development of a severe, generalized, "normal" type of drug eruption. The eruption was distributed over large parts of the surface and was of scarlatiniform, acute appearance. On the second occasion the eruption was even more widespread and hemorrhagic in places, accompanied by a sensation of itching and burning. The cessation of treatment by the drug was followed by disappearance of the dermatitis and other untoward symptoms.

The sensitivity to a drug is sometimes so highly specific that an isomer of that drug will not produce the allergic responses. On the other hand, a group specificity is often present. Quinidine and quinine are alkaloids obtained from the bark of cinchona and chemically closely related, both containing the radical  $C_{20}H_{21}O_8N_7$ . The quinine hydrochloride, nevertheless, taken for three days, caused no trouble. It is remarkable that prior to the administration of quinine hydrochloride no other allergic effects than fixed eruption were present. It was tempting to test the action of quinine hydrochloride after the appearance of the first generalised eruption; but the severe nature of the reaction was a warning against further experiments.

Apart from quinidine, another unrelated and previously well tolerated drug proved to be able to act now as an

allergen and cause a fixed eruption. This bullous eruption, due to phenobarbital, was clinically different from the former, eczematous fixed eruption due to quinidine, but confined to part of the same "fixed" area. The patient seems to have developed a polyvalent, specific sensitivity, which phenomenon is of the highest clinical and theoretical interest.

The role of quinine as an allergen has been widely discussed in many papers, of which the excellent and detailed accounts of M. Sulzberger,<sup>(1)</sup> E. Urbach<sup>(2)</sup> and E. Abramowitz<sup>(3)</sup> are to be cited.

Drug eruptions due to quinine have often been mistaken for scarlet fever. There is no doubt that some cases reported as of *erythema scarlatiniforme recidivans* were caused by quinine (E. H. Molesworth<sup>(4)</sup>). More common are local allergic manifestations of the skin and mucous membranes in the form of eczema—eczematous dermatitis, eczematous contact type dermatitis—after the application of quinine hair tonics and contraceptives. In this kind of allergy the patch test is of paramount importance for evidence of the allergic character of manifestations.

According to L. Chagrin and W. Lelifer,<sup>(5)</sup> arsenicals are the most common cause of fixed eruptions in the United States of America. Phenolphthalein is also not infrequently blamed for fixed eruptions. The reports of various European society transactions mention most often antipyrine and barbiturates as allergens. I had the opportunity to observe a fixed eruption, like *erythema multiforme*, in a physician after the use of sulphanilamides.

#### Summary.

1. A case of drug allergy produced by quinidine is reported.
2. The allergy manifested itself as a fixed eruption.
3. A generalized drug dermatitis was later elicited apart from the fixed type.

4. The patient seems to have developed sensitivity to phenobarbital as well and to present an example of polyvalent specific sensitivity.

#### Acknowledgement.

I wish to acknowledge my indebtedness to Dr. E. H. Molesworth for his help in the preparation of this paper.

#### References.

- (1) M. E. Sulzberger: "Dermatologic Allergy", 1940.
- (2) E. Urbach: "Klinik und Therapie der allergischen Krankheiten", 1935.
- (3) E. W. Abramowitz: "Fixed Eruptions from Various Drugs and Other Agents", *Archives of Dermatology and Syphilis*, Volume XLIII, April, 1941, page 672.
- (4) E. H. Molesworth: "An Introduction to Dermatology", page 68.
- (5) L. Chagrin and W. Lelifer: "Fixed Eruptions Produced by Arsenamine", *The Journal of Investigative Dermatology*, Volume III, December, 1940, page 443.

#### Reviews.

##### PHYSICAL SIGNS IN CLINICAL SURGERY.

To have produced a new (the eighth) edition of Hamilton Bailey's invaluable book "Demonstrations of Physical Signs in Clinical Surgery" under war conditions is surely a worthy effort; but this borders on the heroic when it has been done after the destruction by enemy action of the majority of illustrations and illustration blocks. In this edition the letterpress has been amplified and illustrations have been improved. A glossary of anatomical terms has been added.

Few books can be expected to fulfil so completely and excellently the purpose of their author; it is invaluable to teachers and students, and it should also be ready to hand for regular rereading by every general practitioner.

"Demonstrations of Physical Signs in Clinical Surgery", by Hamilton Bailey, F.R.C.S. (England); Eighth Edition; 1942. Bristol: John Wright and Sons Limited. Demy 8vo, pp. 348, with 455 illustrations. Price: 25s. net.



# The Medical Journal of Australia

SATURDAY, DECEMBER 5, 1942.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

Reference to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: Initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

## THE AUSTRALIAN WAR PHARMACOPŒIA.

EVER since its establishment the Medical Equipment Control Committee has done its utmost to conserve supplies of drugs for the treatment of sick people of the Commonwealth. Some of the drugs that are in everyday use have become scarce for reasons that are by this time well known to every medical practitioner. The same fate has befallen the more unusual medicaments. On previous occasions appeals have been made by the Medical Equipment Control Committee through the columns of this journal for economy in the use of drugs, and it has been suggested *inter alia* that simplicity should be the keynote in prescription writing and that prescriptions of the placebo type should be eliminated. As far as can be learned these appeals have by no means been unsuccessful. The Medical Equipment Control Committee recognizes, as indeed does every organized medical body, that the individual medical attendant is the only person who can determine what drugs shall be used in the treatment of the sick man or woman. It would be foolish even to entertain the idea of any control, by regulation or any other method, of individual prescriptions. It is common sense, however, for the Medical Equipment Control Committee to say in effect to the practising members of the medical profession: "Here is a list of drugs which are obtainable; here is a method in which they may be prescribed for efficient and economical dispensing; if you use these drugs and adopt these methods you will help to promote Australian efficiency under the strain of war." This the committee has done in the publication of the Australian War Pharmacopœia. In the compilation of this volume the Pharmaceutical Advisory Subcommittee, of which Dr. Byron L. Stanton is chairman, has consulted British official formularies, the Australian Pharmaceutical Formulary and pharmacopœia of all the larger Australian hospitals as well as current medical and pharmaceutical journals. Efforts have also been made "to incorporate the more appropriate parts of varying prescribing practices from all the States". We read in the preface:

The selection of medicines included is wide enough in range to cover ordinary therapeutic requirements, but non-essential drugs have been eliminated, while those in short

supply, and others more urgently needed in different phases of the national war effort, have been limited as far as possible or replaced by alternative drugs.

When practitioners order medicaments from this work, they should add the letters "A.W.P." in each instance. The cooperation of Australian pharmacists is being sought and, we may be quite certain, will be obtained. When therefore the practitioner orders, let us say, a mixture bearing one of the usual titles such as are used in this book, the "A.W.P." preparation will be dispensed. The chief responsibility thus rests with the doctor, but his adjutant, the pharmacist, has an important share of responsibility. This "Australian War Pharmacopœia" is issued with every confidence that it will be put to the best possible use. Special attention is directed to a short section on wartime prescribing. Having studied this, practitioners will naturally turn to the details of the preparations in the "general section". In the world of medicine this book is almost as important as reliable munitions in the ordnance department.

## THE TONGUE IN DIAGNOSIS.

THE appearance of the patient's tongue played a great part in medical practice until the advent of precise physical and chemical measurements which could record the dimensions and movements of the viscera and determine quantitatively the composition of body fluids. There was no glossograph invented to assess numerically the size, superficial condition and general behaviour of the tongue, nor did a furmometer emanate from an ultra-modern medical school. In consequence the old-time examination of the tongue as an index to the patient's general health fell into neglect, and this was a pity, for whilst the information given by the ophthalmoscope must be awarded first place in value, the evidence proffered by the tongue is not a bad second. Medical literature in the last century had a long list of descriptive terms applied to pathological states of the tongue such as white strawberry, red strawberry, raspberry, beetroot, raw beef, spider marked, snail track, scrotal, bald and hairy, whilst the movements of this organ in tremor, fibrillar twitching, trombone action, unilateral protrusion and the like were taken seriously in a diagnostic summing up. It is rather humiliating to medical science that so common a condition as a furred tongue should remain unexplained; the microscope may reveal proliferation and desquamation of epithelium, but just why this should accompany or follow, say, an inflated colon has not been disclosed by pathology.

That the tongue can yield valuable information and suggest other methods of clinical examination is now generally admitted, and so inspection of this organ has regained some of its old popularity. Naturally one thinks first of the alimentary canal, in which a departure from normal functioning in any one level produces disturbances in other levels particularly in the upward or oral direction. Then there is the appearance of the tongue in pyrexia in general and in some exanthemata in particular, which the physician recognizes as typical but for which a cause has not been found. The tongue is a highly vascular structure and so can offer immediate information respecting many states of the blood, though there is nothing quite so startling to the patient as the diagnosis of disease of the

<sup>1</sup>A. M. Kennedy: "Diagnostic Importance of the Tongue", *The Practitioner*, Volume CXLIII, 1939, page 573.

kidneys by peering into the eye. It has recently been suggested that dryness of the tongue is the best clinical index of the state of hydration in the body, especially if urine of a high specific gravity is an accompaniment.<sup>1</sup>

It was only to be expected that the widespread attention paid to vitamin deficiency should lead to some attempts to correlate tongue conditions with the various avitaminoses, and quite a considerable literature has already come into being. Lack of nicotinic acid or niacin, to adopt the newer terminology, can bring about a severe glossitis which is classified as pellagra glossitis; at first there is swelling with injection of the tip and lateral margins; this soon spreads, giving a fiery redness with ulceration, tenderness, pain and salivation. If the condition persists the papillae may undergo atrophic change and a dry glossitis ensue. The correctness of the diagnosis in such cases is proved by the dramatic improvement when niacin is administered, the ulcers heal and the vivid scarlet gives way to a healthy pink. When riboflavin deficiency is present the colour is magenta and not scarlet as in the pellagrous type, the epithelium over the papillae swells up, but does not desquamate, giving a granular or "pebbled" appearance. It is generally accepted, however, that the lingual picture is not found alone but associated with other indications of ariboflavonosis such as seborrhoeic dermatitis. In contradistinction to the other members of the vitamin B group a deficiency in the diet of vitamin B<sub>1</sub>, or thiamin, the original antiberiberi vitamin, does not appear to produce any oral change, and experimental deprivation of thiamin in human beings bears out this conclusion. Hyperkeratotic changes in the tongue have been described as due to lack of vitamin A, but it is with the B group that the clinician is most concerned. On the whole it is advisable to administer not one but a plurality of vitamins such as is found in yeast or crude liver extract. Whether the glossitis which characterizes pernicious anemia is due to absence of one of the blood-building factors has not been established; but there is a possibility that the gastric intrinsic agent is involved. Simple lack of iron can also evoke changes in the tongue which administration of this metal remedies. There are other types of glossitis such as Moeller's which may have an origin in some deficiency, but so far convincing proof has not been presented. In ordinary medical practice multiple deficiencies are the rule, and it is suggested that no one vitamin preparation should be regarded as specific; further, however closely the condition of the tongue corresponds to an established picture of this organ associated with deficiency of a single vitamin or group of vitamins, the diagnosis should not be based on this alone but should take into account the other manifestations of the particular avitaminosis.

### Current Comment.

#### INJURIES FROM PROJECTILES.

UNDER existing international conditions, certain aspects of the science of ballistics assume a considerable medical importance. From the earliest days of explosively projected missiles, bizarre effects on the human body have

been noted, but it is only recently that improved methods of investigation, such as spark photography, have enabled accurate observations to be made regarding the wounding mechanism of high-velocity projectiles. The obvious disproportion in many instances between the size of the missile and the amount of tissue destruction has often occasioned comment, and has been attributed to various causes, such as the irregular shape of bomb splinters or the rotary movement of rifle bullets. Professor Sydney Smith, of the Department of Forensic Medicine in the University of Edinburgh, has discussed this subject.<sup>1</sup> He emphasizes the fact that medical men are often required to give an expert opinion regarding wounds, and that grave consequences may follow if a doctor is not sufficiently instructed. Even diplomatic and political repercussions may result since normal projectiles sometimes cause wounds which the inexperienced may attribute to expanding or "dum-dum" bullets. Thus an ordinary rifle bullet may produce an enormous hole in a thigh with the tissues pulped and portion of the femur reduced almost to powder. Professor Smith attributes this explosive effect partly to the speed of the bullet causing surrounding structures to be thrust violently out of its path, and partly to the rotation of the bullet. It has, of course, been known for some time that a rifle bullet does not assume a steady "spin" until it has travelled several hundred yards. Leaving the muzzle, the bullet is rotating at about 3,000 turns per second, and is, in addition, executing a wobbling motion owing to the tail of the bullet revolving around the line of trajectory, in fact, performing a "tail-spin". There can be no question that any irregular rotation at such extreme angular velocities (circa 180,000 revolutions per minute) would exert a powerful displacing effect on any adjacent medium. Recent work by A. N. Black, B. D. Burns and S. Zuckerman<sup>2</sup> has demonstrated the part that is played by the linear velocity of the missile. A model gun was devised which was capable of firing a spherical 3/32" steel ball weighing 53 milligrammes at velocities ranging from 500 to 5,000 feet/second. The targets used in the experiments consisted of rectangular blocks of 20% gelatin 4.0 by 4.0 by 5.0 centimetres. Spark photographs show clearly the enormous distortion caused by the passage of a high-velocity projectile. A "tail-splash" and a "head-cone" develop as the ball enters and emerges from the target, but the maximum deformity is seen after the ball has left the target, and consists of the expansion of the block to three or four times its original volume. In spite of this distortion the blocks of gelatin return to their previous shape and size and the only permanent visible effect is a small thread-like track similar to that caused by pushing a needle through the block. The amount of distortion was reduced when the block was enclosed in a "skin" made from a bicycle inner tube, and it is reasonable to assume that the human skin exerts a similar retentive influence. Spark photographs were made of the hind limb of an anesthetized rabbit when a ball was fired through it, and showed the same type of distortion. The expansive changes in the gelatin blocks described above can be explained only as being due to the formation of a cavity within the blocks with explosive violence. As the missile passes through the block it imparts motion to the particles in its track, and these fly off radially, imparting their momentum in turn to further particles, to such effect that the solid rectangular gelatin block is converted into a peripheral layer of gelatin approximately 0.5 centimetre in thickness surrounding a central cavity about 5.0 centimetres in diameter. When the extent of such distortion is considered, it can be appreciated that in animal tissues, structures at a distance from the actual track of a bullet may suffer considerable damage. Burns and Zuckerman found that their tiny projectile would shatter a rabbit's femur even though its track was more than one centimetre away from the bone. Elastic structures, such as arteries and nerves, were found to be much less vulnerable; thus an excised strip of artery containing fluid at a pressure of 100 millimetres of mercury and embedded in a gelatin block did not rupture unless actually struck by the ball. It is

<sup>1</sup>Harold Jeghers: "The Appearance of the Tongue as an Index of Nutritional Deficiency". *The New England Journal of Medicine*, August, 1942, page 321.

<sup>2</sup>Edinburgh Medical Journal, December, 1941.

<sup>3</sup>British Medical Journal, December 26, 1941.



probable that nerves, while remaining macroscopically intact under similar circumstances, can be expected to suffer some interference with conduction, and this is in agreement with the clinical observation that transient paralysis and analgesia sometimes follow wounds near the line of nerve trunks.

### "THE MEDICAL ANNUAL" FOR 1942.

A COPY of "The Medical Annual" for 1942 has arrived from England.<sup>1</sup> Many Australian practitioners last year were disappointed because large numbers of "The Medical Annual" for that year failed to arrive. The place of this volume in medical practice is clear when we state that its sub-title, "A Year Book of Treatment and Practitioner's Index", is more than justified. The unfailing regularity with which this book has appeared since the outbreak of war is just another indication of the undying spirit of Britain; the publishers, John Wright and Sons, Limited, of that much bombed city of Bristol, should be congratulated on the maintenance of the general get-up and style of the present volume which is quite up to the standard of previous volumes.

The review of the year's work is as usual under the editorship of H. Lethby Tidy on the medical side and A. Rendle Short on the surgical. Among the contributors who are well known in English medical literature, four new names appear—Lord Horder, W. E. Lloyd, T. P. McMurray and C. P. G. Wakeley. The subjects that have to do with war medicine and surgery have been given a fairly large amount of space. The article on war psychiatry is based on twenty-seven contributions to the literature and Aubrey Lewis has produced a readable summary. Prominence is given to a circular dealing with the feeble-minded and the insane and issued by the Selective Service System of the United States. It is described as straightforward and practical and we are told that it would enable the examining physician, if he were not himself a psychiatrist, to recognize all those whom he should refer to the Advisory Board's psychiatrist. The article on war surgery by Lambert Rogers covers eighteen contributions to the literature. Reference is made here to the work of Bonnin and Fenner of South Australia on the implantation of sulphadiazine in wounds. An article by J. A. Shepherd is mentioned and we are reminded that when excision of wounds is carried out it must be early and adequate; the surgeon needs to be skilled and a nicety of technique is required. Reference is made to the experimental work by Bywaters on crush syndrome. W. Ernest Lloyd has written on mass radiography of the chest in the light of eighteen articles, among whose authors are several Australian workers. The conclusion stated is that the ideal method of detecting pulmonary tuberculosis in the young adult population is to carry out mass radiological surveys on boys and girls when they leave school and to repeat the radiological examination at yearly intervals until adult life is reached. Cerebro-spinal fever is discussed by H. Stanley Banks in the light of twenty-two contributions. The complications which receive considerable mention include chronic meningococcal septicaemia, suppurative haemorrhage, glycosuria and ketosis and double infection of the meninges with the meningococcus and Gärtner's bacillus. Chemotherapy is discussed fully. We learn incidentally that the chemotherapy of meningococcal disease is less advanced in Germany than in Great Britain. In the article on burns of war it is stated that experience has shown that there is no contra-indication to the use of coagulation methods in the treatment of war burns. Lord Horder's article on health in air-raid shelters is important.

From this short account of some of the features of this year's "Medical Annual" readers who do not know this publication will learn what kind of book it is. We prophesy that once readers have acquired what on previous

occasions has been called the "Medical Annual habit" they will not lose it. In these days of hurry and crowded work it is not always easy to find time for reading. The habit of reading and of reference to current literature must be cultivated; it is all too easily lost. "The Medical Annual" is a stimulating as well as a ready book of reference.

### SULPHADIAZINE AND ACUTE SUPPRESSION OF URINE.

SULPHADIAZINE has been described by the Council on Pharmacy and Chemistry of the American Medical Association as having toxic effects which are less than those of other drugs of the sulphonamide series. It is absorbed more slowly than sulphathiazole or sulphanilamide and is excreted more slowly. Sulphadiazine is widely used in the United States of America and signs are not wanting that it will become fashionable in this country. Already some of our clinicians are reported as having stated that it has no toxic effects. In these circumstances attention should be drawn to a report by J. W. Schulte, F. P. Shidler and J. J. Niebauer who write from the Department of Surgery and the Division of Urology of Stanford University School of Medicine.<sup>1</sup>

These authors describe a case of acute suppression of urine which occurred in a man aged twenty-six years after he had received 25 grammes of sulphadiazine. The patient had been operated on for the removal of an orbital tumour. Examination of the urine before operation revealed no abnormal constituents and the urinary pH was 6.0. Red blood cells were found in the urine on the fifth day after operation which was the fifth day of sulphadiazine administration. The urinary output which for the first four days after operation had been between 1,500 and 2,400 cubic centimetres per day, fell to 300 cubic centimetres. At the same time the patient complained of abdominal pain radiating to the bladder region. On the following day 350 cubic centimetres of urine were passed, and after the voidance of 180 cubic centimetres of blood-stained urine on the seventh day, no more urine was passed. A cystoscopic examination was made and both ureters were found to be obstructed by sand-like granular material consisting of sulphadiazine crystals. It is to be noted that in this instance complete suppression of urine did not take place until two days after the first appearance of symptoms. As soon as symptoms occurred, administration of the drug was stopped, and large amounts of fluid were given by mouth, as well as an intravenous injection of a litre of 5% solution of dextrose. After catheterization the patient was also given by mouth four grammes of sodium bicarbonate every three hours. The urinary output slowly increased and returned to normal.

In discussing their case, Schulte and his fellow workers state that apparently either crystals are formed in the collecting tubules of the kidney, from which they pass to the pelvis to form large masses, or else crystals are precipitated in the renal pelvis by some change in the colloidal mechanism of the urine. They also refer to cases taken from the literature in which diazine crystals were found in the urinary tract, and to a case in which one of their number performed a post-mortem examination on a man who died after pneumonectomy and during the eleven days before death had taken 54 grammes of sulphadiazine. In this instance amorphous yellowish orange granular deposits were found in the right renal pelvis and along the entire course of the right ureter. This granular substance gave the typical diazo reaction of sulphadiazine. The important point for the clinician to remember is that bicarbonate of soda should be given at the same time as sulphadiazine and in amounts sufficiently large to make the urine alkaline. This statement is backed by clinical and experimental observations which are quoted by Schulte and his colleagues. Probably a good deal remains to be learned about sulphadiazine, though the present indications are that it is a relatively safe drug. Its use must be made as safe as possible.

<sup>1</sup> The Journal of the American Medical Association, May 30, 1942.

<sup>1</sup> "The Medical Annual: A Year Book of Treatment and Practitioner's Index", edited by H. Lethby Tidy, M.A., M.D. (Oxon.), F.R.C.P., and A. Rendle Short, M.D., B.S., B.Sc., F.R.C.S.; 1942. Bristol: John Wright and Sons Limited. London: Simpkin Marshall (1941) Limited. 8½" x 5½", pp. 516, with many illustrations, some of which are in colour. Price: 20s.

## Abstracts from Medical Literature.

### SURGERY.

#### Succinyl Sulphathiazole.

W. M. FIBOR (*Annals of Surgery*, May, 1942) discusses the attainment of intestinal asepsis with sulphonamides. Sulphanilylguanidine was found unsatisfactory for various reasons. It was ineffective in ulcerative lesions, and against certain pathogenic bacteria in the bowel. To bring about a significant reduction in the bacterial count in the stool required large doses at four-hourly intervals. These observations, together with the occurrence of mild toxic reactions, led the author to commence a systematic search for a compound of high antibacterial potency, low toxicity and poor absorbability from the alimentary canal. Succinyl sulphathiazole was found to satisfy the requirements. It has a low toxicity and absorbability, and is highly potent in lowering the number of coliform bacteria in the stool. It is given in doses of 0.25 gramme per kilogram of body weight, and is of value in reducing the bacterial count before intestinal anastomosis. In these operations the author advises the administration of the drug for seven days before and for ten days after operation. The presence of diarrhoea interferes with the action of the drug, and is an indication for doubling the dose. Cathartics and mineral oil should be avoided during its use. Succinyl sulphathiazole is very effective against *Bacillus coli* and *Bacillus dysenteriae* (Shiga, Flexner and Sonne), but inactive with *Bacillus typhosus*, a *Streptococcus faecalis* and *Bacillus proteus*.

#### Thrombophlebitis of the Lower Limb.

A. STARR *et alii* (*The Journal of the American Medical Association*, April 4, 1942) describe a radiographic procedure for the diagnosis of thrombophlebitis of the deep veins of lower limbs. The patient lies on his back with a block six centimetres high under the heel. A 14-inch by 17-inch X-ray film is placed under the leg, its lower edge about three inches above the ankle. A small incision is made about one centimetre behind the lateral malleolus. A small vein is found here which communicates with the deep venous system. Through a fine needle 20 mls of a 35% solution of diodone ("Diodrast") are injected at a uniform rate during a period of sixty seconds; then a skiagram is made. In the presence of thrombophlebitis it is found that no contrast substance has entered the deep veins of the calf or the popliteal or the femoral vein, which are normally well outlined. Thrombophlebitis may be suspected from an abnormally large calibre of the vein at the ankle or from resistance to the injection.

#### Aseptic Immediate Anastomosis.

J. H. GIBSON, JUNIOR, AND CLARE C. HOGUE (*Annals of Surgery*, October, 1941) present a review of 120 cases of carcinoma of the colon with a view to determining the operative mortality associated with the three main types of operative procedure: immediate aseptic

anastomosis, extraabdominal resection with delayed anastomosis, and immediate anastomosis of the opened bowel. The authors point out that no type of major operative procedure to remove the growth should be performed in the presence of obstruction of the colon; a caecostomy or colostomy should be performed first as far as possible from the growth. Contamination of the peritoneum must be avoided by exteriorization of the growth or by aseptic anastomosis. Late peritonitis is due to leakage or necrosis of the bowel wall. Both may be due to interference with the blood supply and the technique employed must be adapted to this possibility. The sulphonamide group of drugs are of value in colonic surgery.

#### Cardiospasm.

THE condition of cardiospasm is described in detail by Carl Eggers (*Annals of Surgery*, February, 1942). The aetiology is still undecided. Plummer and Vinson state that it is not a neurosis. Experimental and clinical observations alike are confusing, but evidence is accumulating that the condition is due to a neuro-muscular dysfunction resulting from pathological changes, especially in Auerbach's plexus. The cause of these changes is not yet determined. Cardiospasm appears to be common in Brazil, and Etzel observed 626 cases in patients over eighteen years of age. Most of these patients came from rural districts of Brazil where the diet is poor and inadequate, and especially low in vitamin B<sub>1</sub>. He noted a frequent association between cardiospasm and megacolon. The diagnosis can usually be made after an investigation of the nature and duration of symptoms, passage of a sound, oesophagoscopy, and X-ray examination. Simple stricture and carcinoma must be excluded, and also a condition of spasm of the lower end of the oesophagus secondary to an intraabdominal lesion. In discussing treatment, the author points out that spontaneous recovery never occurs, and that no treatment can be considered curative. By the time hypertrophy and dilatation have occurred, the condition has become permanent from the anatomical point of view, and the causative damage cannot be corrected. Treatment is therefore symptomatic, aimed at the improvement of drainage from the oesophagus to the stomach. Some patients are kept comfortable by care in diet, patients differing considerably in what does or does not suit them. Antispasmodics and sedatives may help in early cases, but more energetic treatment is often necessary. In these, the passage of sounds, possibly over a previously swallowed thread of silk, may give adequate relief. In others, gradual stretching by dilators of various types may be necessary. After dilatation of the cardia, it must be remembered that the oesophageal changes are still present. Care must still be exercised over diet, over-loading being avoided. It may be helpful to give local treatment such as daily irrigations of the oesophagus with saline solution. In severe cases in which gross loss of weight and dehydration have occurred, gastrostomy may be necessary, followed later by manual dilatation from below, or retrograde oesophagoscopy and dilatation with bougies. In cases in which mechanical dilatation from above fails, the safest and simplest operation

appears to be manual dilatation from below through a small temporary incision in the stomach. In the occasional presence of a very dilated, elongated and sacculated oesophagus, oesophago-gastrostomy may be performed, preferably through an abdominal approach. Other procedures such as attempts at complete sympathetic denervation of the area do not appear justified, as they are operations of considerable magnitude, and even if it is possible to complete them successfully, they will not restore the oesophagus to a normal condition. They may relieve the symptoms, but this can be done more safely by one of the lesser procedures. In the great majority of cases, symptomatic relief is possible either by mechanical dilatation from above, or rarely, by manual dilatation from below. Neither of these operations entails any undue risk.

#### Refrigeration in Amputation.

F. W. BANCROFT, A. G. FULLER AND W. F. RUOGHERO (*Annals of Surgery*, April, 1942) describe their experiences with refrigeration as a means of inducing anaesthesia in limbs requiring amputation. Their patients were elderly, poor-risk types with diabetic gangrene, and in the cases described amputation was performed through the thigh. The authors express themselves as satisfied that the method possesses very definite advantages in the type of patient referred to. Anaesthesia was satisfactory and did not require to be supplemented even with morphine. Shock was absent or minimal, there being no appreciable change in either pulse or blood pressure. The patients took their normal food up to the time of the operation, and were usually able to eat a good meal on their return to bed. Healing was satisfactory. The method employed by the authors consists of first refrigerating with cracked ice the site at which the tourniquet is to be placed. After ten minutes a flat rubber tourniquet is applied, and the limb is immersed in a bucket containing ice-water and cracked ice, to a level about two inches above the tourniquet. Refrigeration is continued for one and a half hours for leg amputations, and for two hours in thigh amputations. Anaesthesia lasts about one hour. After operation the part is gradually de-refrigerated, a small dressing being applied and the stump surrounded by ice-bags. The authors emphasize that the limb is "refrigerated", but not frozen.

#### Glomus Tumours.

CONSTANCE M. OTTLEY (*The British Journal of Surgery*, April, 1942) records a case of glomus tumour in an unusual site, namely, on the back of the neck. Older writers used to speak of examples of "painful subcutaneous tubercle". Some of these tumours may have been glomus tumours, but no microscopic confirmation was obtained. But in 1920, Barré published the report of an undoubted case, and many more have followed. The cutaneous glomus, a normal structure in certain portions of the skin of warm-blooded animals, including man, was first accurately described in 1852. Glomera in man are usually described as occurring almost exclusively on certain areas of the hands and feet. The glomus is a specialized anastomotic mechanism connecting a terminal arteriole with a primary venule. The anastomotic



vessel is S-shaped. The wall has an endothelial lining and two ill-defined muscular layers, an inner longitudinal and an outer circular. Among the muscle cells lie groups of clear epithelioid cells—the so-called glomus cells. The outer zone of the anastomosis consists of a collagen network in the meshes of which are numerous non-medullated nerve fibres. The entire anastomosis is surrounded by fibrous tissue containing a plexus of collecting veins. The function of the organ is still uncertain, but it appears that it may be concerned in some way in regulating temperature, either local or general. The microscopic picture of the glomus tumour shows all these various components in disorderly fashion and in varying proportions. Most important, from the diagnostic viewpoint, is the presence of the glomus cells. The tumour takes origin in the deeper layers of the skin, and may grow outwards towards the surface or into the deeper tissues. It does not show malignant characters, but may cause pressure atrophy, for instance, of the terminal phalanx in subungual tumours. The nodule is usually quite small, and handling often causes severe pain. There may be a constant aching pain, or there may be attacks of severe pain coming either spontaneously or in response to some interference which may be quite slight, such as the touch of clothing. The pain may be localized to the tumour, but often is of a radiating neuralgic type. More rarely, sympathetic disturbances may occur, such as flushing and warmth, pallor and coldness, or sweating. Other signs may be under-development of the affected part or tremor. Treatment is by excision. Local anaesthesia may be adopted, but plenty of the anaesthetic solution must be used as the tumour seems to be particularly resistant to local analgesics. In two cases, X-ray therapy was unavailing. Diagnosis of the condition is important. Mistaken diagnosis has led to the treatment of patients, sometimes for years, as psychoneurotics, and also to over-drastring surgery, such as amputation of a whole or part of a finger or cervical sympathectomy.

#### Regional Enteritis.

R. WARREN AND R. H. MILLER (*The New England Journal of Medicine*, April 9, 1942) report a series of forty-three cases of regional enteritis, with a discussion particularly of the results of treatment. Four types of clinical pictures in this disease have been described: the acute (simulating appendicitis), the diarrhoeic, the obstructive, and the fistulous. The authors recognize a fifth type, namely, the symptomless; five cases of this type were encountered. The disease appears to affect mainly young people, the average age being thirty years. The terminal part of the ileum is the most common site of the lesion, but other portions of bowel may be involved. The diagnosis is usually made by pathological examination, by gross observation at operation, or by X-ray study. Pathologically, the lesion is a chronic granulomatous process in the intestinal wall and mesentery. Microscopically, the picture is one of a non-specific chronic inflammation, with occasional giant cells, and even epithelioid cells. The aetiology of the condition is obscure. The treatment almost

universally adopted has been conservative therapy in the early acute cases, and surgical intervention in the well-established cases. Surgery may comprise either resection, or a short-circuiting operation. The result of these various forms of treatment in the present series is analysed. The most successful treatment was the conservative type, but this was almost exclusively reserved for the acute cases. The authors have found the results of surgical treatment disappointing, but they consider that it should not be abandoned in the well-established cases for conservative measures. It is extremely rare for such patients to become spontaneously symptom free. Resection will result in a percentage of cures, though this percentage may be small. The prognosis without surgery in the established case, or in the case in which surgery has failed to give relief or been followed by recurrence, is poor. The course is most commonly slowly and progressively downward. In a few cases the disease appears to remain stationary.

#### Benign Tumours of the Stomach.

E. M. FINE SILVER (*Surgery*, August, 1942) discusses simple gastric tumours, and reports nine cases seen at the New York Hospital over a period of eight years. One of the earliest examples of this condition was reported in 1907 by Gibson, and numerous reports have appeared since that date. It appears, however, that cases are constantly being overlooked. It is of importance that an early diagnosis should be made, in view of the complications which may occur. Of these, malignant degeneration is the most serious. Of the nine cases presented in the present communication, three already showed this complication. Another complication is bleeding with consequent anaemia. The anaemia is usually of the secondary type, but in long-standing severe cases, pernicious anaemia may be suspected. Severe bleeding with haematemesis and melena is uncommon. Symptoms are usually slight, except when a pedunculated tumour causes ball-valve obstruction of the pylorus, or when, owing to its size, the tumour interferes with gastric motility and secretion. There are no characteristic digestive symptoms. With improvements in radiological technique, pre-operative diagnosis is being made more frequently than heretofore. A circumscribed punched-out filling defect may be seen after barium meal, with no evidence of spasm or disturbance of peristalsis. Pathologically, the tumour may be of epithelial or mesenchymal origin. The leiomyoma appears to be the most common type. Epithelial adenoma is also relatively common. In most cases the tumour appears to be amenable to local excision, usually by transgastric approach. In the case of large tumours, or when malignant change has supervened, partial gastrectomy is the operation of choice.

#### Mixed Salivary Tumours.

L. H. HEMPLEMANN, JUNIOR, AND N. A. WOMACK (*Annals of Surgery*, July, 1942) discuss the pathogenesis and histogenesis of mixed salivary tumours. After briefly reviewing the ideas which have been advanced on these subjects, they discuss the histological features of mixed tumours, and emphasize the

fact that epithelial tissue may be seen to merge gradually and almost insensibly into myxomatous. The authors decided that the transition could not be explained on a morphological basis. They proceeded, therefore, to carry out a histo-chemical investigation of the mucoid material. One of the authors devised two methods of staining which permitted differentiation between the chondroitin sulphuric acid complex which is characteristic of mesenchymal mucoids and the mucotin sulphuric acid complex found in epithelial secretions. When the differential method was applied to the tissues of "mixed" parotid tumours, a mixed reaction was observed. The myxomatous areas gave the reaction of mesenchymal mucoids, while in the acini the mucoid material stained in the same way as that in epithelial mucin of salivary glands and alimentary and respiratory tracts. The authors discount the suggestion that reciprocal chemical mutation can explain their findings, and also the view that metaplasia of epithelial cells takes place. They conclude, therefore, that there are two types of tissue present in "mixed" tumours. They insist that normal development depends on a mutual "organizer" action of epithelial and connective tissues on each other, and refer to the work of Drew, who showed that tissue cultures of kidney epithelium or breast carcinoma grow in sheets and exhibit no tendency to form duct-like structures unless fibrous tissue cells are present. The authors consider that mixed tumours arise from primary epithelial maldevelopment, with mesodermal differentiation secondary to this disturbance.

#### Cephalin Cholesterol Test in Jaundiced Patients.

The cephalin cholesterol test has been further investigated by S. H. NADLER and M. F. BUTLER (*Surgery*, May, 1942) in order to provide further evidence as to the usefulness of a biological test to determine the need for surgical intervention in a jaundiced patient and to enable a decision to be made as to whether jaundice is due to obstruction of extrahepatic ducts or destructive processes in the liver itself. The test gives negative results in normal individuals; the result is only rarely if ever positive in patients without hepatic disease. It is a more sensitive indicator of active liver parenchymatous disturbance than any of the so-called liver function tests. It provides the best available index of the prognosis in liver disease, especially cirrhosis.

#### Cotton Suture Material.

R. S. SPARKMAN AND W. H. WILLIAMS (*Surgery*, May, 1942) tell how they have tried as a suture material cotton of the plain non-mercerized variety either black or white. After boiling for twenty minutes or autoclaving for fifteen minutes at fifteen pounds' pressure, number 80 black was used for skin suture, 100 white for ligation of superficial vessels and 50 to 80 for the remaining layers of the McBurney method in appendectomy. These operations were done in a tent operating theatre in the field hospital used in army manoeuvres. The authors are satisfied that cotton is a satisfactory suture material in clean, contaminated or infected wounds.

## British Medical Association News.

### SCIENTIFIC.

A MEETING of the New South Wales Branch of the British Medical Association was held on September 17, 1942, at Sydney Hospital. The meeting took the form of a series of clinical demonstrations by members of the honorary medical staff of the hospital.

#### Acromegaly.

Dr. E. H. STOKES showed a man, aged forty-six years, who presented the typical features of acromegaly. He had recently been operated upon for hemorrhoids, but complained of no symptoms resulting from the acromegalic condition. X-ray examination of the skull revealed that the pituitary fossa was considerably enlarged, and there was also evidence of increased intracranial pressure. The terminal phalanges of the fingers were expanded. The basal metabolic rate was +1%. The serum cholesterol content was 200 milligrammes per 100 cubic centimetres, and although glycosuria was present, a normal result was obtained to the glucose tolerance test. As the patient's visual fields and his fundi oculorum were normal, Dr. Stokes remarked that it was proposed to keep him under observation.

Dr. Stokes also showed a woman, aged forty-nine years, who had been referred to the hospital by Dr. T. J. Biggs. She had first been examined on February 27, 1942. She complained of falling vision of twelve months' duration, with severe headaches, occipital and frontal, during the past two and a half months. Her feet, hands and head had increased in size during the past twelve months. Her visual acuity was considerably impaired, being  $\frac{1}{20}$  in each eye. The optic disks were paler than normal. A chart of the peripheral fields of vision disclosed bi-temporal hemianopia. An X-ray examination revealed considerable enlargement of the pituitary fossa. The serum cholesterol content was 350 milligrammes per 100 cubic centimetres. On April 13 Dr. W. Lister Reid performed right craniotomy and removed an eosinophilic adenoma of the pituitary gland. After operation the patient showed progressive improvement, and her vision at the time of the meeting was normal.

#### Myeloid Leuchæmia.

Dr. Stokes's next patient was a woman suffering from myeloid leuchæmia. She had been referred to the hospital by the superintendent of the Dental Hospital, where it had been noticed that bleeding followed dental extractions. The spleen was considerably enlarged, and a blood count on July 8 gave the following result: the erythrocytes numbered 4,050,000 per cubic millimetre, the hæmoglobin value was 10.3 grammes per 100 cubic millimetres (87.5%) and the colour index was 0.84; the leucocytes numbered 100,500 per cubic millimetre, 26.5% being neutrophile cells, 1% eosinophile cells, 2.5% basophile cells, 4.5% lymphocytes, 3.5% monocytes, 40% band forms, 13.5% metamyelocytes, 7% neutrophile myelocytes and 1.5% myeloblasts. The platelets were scanty. The hæmoglobin content of the erythrocytes was full. Slight anisocytosis was present, occasional macrocytes and microcytes being seen. A few poikilocytes were observed. Slight polychromasia was noted, and four nucleated erythrocytes were seen while 200 leucocytes were being counted. Although the patient's general condition was excellent, the leucocytes had increased in number to 300,000 per cubic millimetre on September 11. Dr. Stokes said that this patient illustrated the importance of making a full blood count in any case of excessive bleeding.

#### Pulmonary Tuberculosis Nine Years after Treatment with Artificial Pneumothorax.

Dr. Stokes then showed a woman, aged twenty-five years. She had been aged sixteen years when she was first treated for right subapical tuberculosis by means of artificial pneumothorax. After the pneumothorax had been maintained for a period of about six months, a large amount of fluid formed in the right pleural cavity. This was aspirated, and the patient made a good recovery. About two years later it was seen that the right side of the chest wall was considerably retracted, and an X-ray examination revealed displacement of the heart and mediastinum. In August, 1925, the right phrenic nerve had been crushed by Dr. M. Susman. At the time of the meeting the retraction of the right side of the chest was obvious. X-ray examination indicated fibrosis and collapse of the right lung. Dr. Stokes pointed out that the result of the pneumothorax treatment was similar to that produced by thoracoplasty.

#### Electrocardiograms.

Dr. Stokes finally showed a series of electrocardiograms illustrating the changes occurring in myxœdema before and after treatment. He said that the QRS complexes, which were of small amplitude, and the T waves, which were isoelectric, returned to normal after thyroid medication.

#### Diabetes Mellitus.

Dr. W. L. CALOV showed a number of diabetic patients. The first was a man, aged fifty-one years, who had felt quite well until February 2, 1942, when he was seized with renal colic. Glycosuria was discovered then on routine examination. He thereafter lost a great deal of weight. He was admitted to hospital suffering from diabetes and thyrotoxicosis, a not uncommon combination. He was emaciated and weak, and his auricles were fibrillating. The basal metabolic rate was +23%. Because of the thyrotoxicosis and emaciation he had to be given a nutritious diet; but, although he was allowed a diet with a value of over 3,000 Calories, he was still ravenously hungry. On one occasion he surreptitiously ate a whole rabbit. At this time the patient was having large doses of insulin, and was still passing large quantities of sugar in the urine. Dr. Lealie Dunlop recommended reduction of the amount of insulin. A change for the better was almost immediate. The voracity disappeared and the appetite became normal; the urine became free of sugar, and the patient increased in weight and strength.

Dr. Calov said that when too large doses of insulin were given, hypoglycæmia occurred and caused an increase in appetite; it also evoked a response from the adrenals, so that more sugar was poured into the circulation; the hypoglycæmia was then replaced by hyperglycæmia. The patient under discussion provided evidence in support of that view. At one time he was taking 110 units of insulin a day. At the time of the meeting he was taking only 30, and he was gaining in weight and had been transformed from an apparently hopeless invalid to a brisk, well-nourished, energetic man.

Dr. Calov's next patient was a woman, aged thirty-three years, who used to weigh 20 stone and at the time of the meeting weighed 17 stone 9 pounds. She had been treated in hospital for obesity three and a half years earlier and she was subjected to cholecystectomy at that time. For the past twelve months she had suffered from pain in the right iliac region. During that period she had been aware that she was a diabetic. She was subjected to appendicectomy a few weeks prior to the meeting. While she was in hospital, her glucose tolerance was estimated. Dr. Calov drew attention to the gross obesity, fresh complexion, soft skin, comparatively small hands and feet, and to the folds of fat in the latissimus regions and an abdominal apron of fat. He said that the patient menstruated regularly and normally, and she had borne children. The carbohydrate metabolism was gravely disturbed. Her condition was one of so-called pituitary obesity associated with diabetes. The first object in treatment would be to reduce the obesity.

The next patient shown by Dr. Calov was a girl, aged sixteen years, who worked as a dressmaker. She was having a diet with a value of 1,700 Calories, and she took insulin in doses of 36 units in the morning, 8 units at midday and 32 units in the evening. For a time she was taking zinc protamine insulin; but she was then subject to severe hypoglycæmic reactions. Her blood sugar content would swing suddenly from very high to very low. Despite the hypoglycæmic reactions, her urine usually contained sugar when she attended the clinic. Until the day before the meeting she had been having rather larger doses of ordinary insulin. The dose was altered then because she had had a reaction on the previous night, and she complained of frequent headache. She felt well generally and looked remarkably well.

The last patient shown by Dr. Calov was a girl, aged fourteen years. She was receiving a diet of 2,140 Calories and 52 units of insulin in the morning and 32 in the evening. Her blood sugar content was unstable. The diabetes was difficult to control; she passed large quantities of sugar in the urine. She was not working at the time of the meeting. Dr. Calov thought that possibly improvement would take place when the patient was able to utilize more of her blood sugar by exertion. She was very liable to ketosis until the carbohydrate content of her diet was increased. She looked well and felt well.

Dr. Calov also showed a series of graphs illustrating various kinds of response to the glucose tolerance test.



**Syringomyelia.**

DR. H. L. SPEARMAN showed a male patient, aged twenty-three years, a "Duco" sprayer by trade, who complained of wasting and weakness of the hands, of gradual onset and present for over six years; the condition had been painless until lately, when the right elbow began to ache a little sometimes. Six years earlier he had noticed the condition in the right hand, and it was followed in twelve months by a similar condition in the left hand. Lately the little fingers had been drawn up and the hands were losing their shape. The patient often burned himself on the hands without knowing it, and he was conscious of a feeling of numbness. He had also burnt his shins on the radiator. He was suspected of having leprosy polyneuritis, but was fully investigated, with negative results. No other member of the family was affected. Both hands were wasted. There was atrophy of the intrinsic muscles of both hands with a tendency to "claw-hand" from contractures. Thermal and pain sensation were absent. Light touch, vibratory and joint sense were normal. A patchy, diffuse thickening of the subcutaneous tissues was present, and the hands were scarred from burns and abrasions.

**Dextrocardia, Auricular Fibrillation and Diabetes Mellitus.**

Dr. Spearman also showed a male patient who had dextrocardia (transposition of viscera), associated with auricular fibrillation, and complicated by diabetes mellitus. An electrocardiographic tracing revealed right-sided preponderance.

**Jaundice, Oedema and Ascites.**

On behalf of Dr. T. E. H. SPARK, who was unable to be present, Dr. E. H. STOKES and Dr. HELEN TOOTH showed four patients. The first was a girl, aged nineteen years, who had first sought treatment twelve months previously, because of the appearance of jaundice, together with oedema of the legs and ascites; the jaundice was of the regurgitant variety, associated with bile in the urine and a direct positive reaction to the Van den Bergh test. The liver and spleen were not palpable, and special methods of investigation were unproductive of definite results; tests of cardiac and renal function gave entirely normal results; the Wassermann, Casoni and Mantoux tests all failed to produce reactions. Radiological investigation revealed no abnormality, but examination of the blood revealed a moderate degree of anaemia of the macrocytic variety, with a colour index greater than unity; fragility tests on the red cells produced results within normal limits.

The patient was treated by rest in bed, and the oedema and ascites cleared up within three weeks, but a slight degree of icterus remained and had been present ever since. During the last twelve months the patient had had several acute exacerbations of symptoms, accompanied by pyrexia and epigastric pain, which had subsided within a short period of bed rest. For some weeks after each attack the oedema and jaundice were more pronounced, and the attacks appeared to be growing more frequent and severe, and the degree of recovery less obvious. The condition of the blood had responded to parenteral liver therapy, but all other treatment appeared to be unavailing. Dr. Spark was of the opinion that cirrhosis of the liver was the underlying cause of the condition, but was unable to throw any light on its aetiology; prognosis was regarded as poor, for the condition appeared to be progressing steadily towards complete hepatic failure.

**Rheumatic Carditis.**

Dr. Spark's next patient was a boy, aged nine years, suffering from rheumatic carditis; there was a clear-cut history of acute rheumatic fever several years previously. The case was shown to illustrate the classical, fully-developed effects of acute rheumatism on the mitral valve. The patient exhibited the palpable thrill together with the typical presystolic murmur so characteristic of mitral stenosis; the facies was also quite typical. It was considered rather uncommon to find such pronounced signs in one so young.

**Cretinism.**

Dr. Spark's third patient was a child, who had first been examined in January, 1942, when aged thirteen months; the typical signs of cretinism were then present. A photograph had been taken at that time, so that any improvement could be more accurately assessed, and a comparison of this picture with a recent photograph revealed a really striking change in the child's appearance. Treatment had consisted of the administration of very small doses of thyroid extract,

which had been gradually increased to 0.5 grain three times a day; this appeared to be the appropriate maintenance dose. Together with this, the child was now receiving calcium lactate, five grains three times a day, and vitamin D, and improvement in her condition was being satisfactorily maintained.

Dr. Spark emphasized the paramount importance of early diagnosis in such cases, and the necessity for prolonged treatment if relapse was to be avoided.

**Congenital Syphilis and Rickets.**

Dr. Spark's last patient was a female infant, aged ten months, who had been a weakly child at birth, and had spent the first six or seven months of her life in various hospitals; she had been treated for "bronchitis", "frequent motions" and "malnutrition" on different occasions.

On examination, the child was found to weigh nine pounds; she was pale, inactive and "snuffling". Examination of the head revealed pronounced parietal and frontal bossing; the fontanelles were almost closed and the nasal bridge was sunken. The limbs were wasted and grossly hypotonic. The abdomen was prominent and lax, but neither the liver nor the spleen was enlarged.

The appearance of the child was more suggestive of rickets than of congenital syphilis; but the Wassermann test produced a completely positive reaction, so it was assumed that both conditions coexisted. Treatment had consisted of the administration of orange juice, cod liver oil and calcium lactate, together with potassium iodide and mercury by mouth. The child was also given a course of intramuscular injections of sulpharsphenamine; the first dosage used was ten milligrammes per kilogram of body weight, and this was increased by five milligrammes per kilogram at intervals of one week. It was pointed out that the child had had several attacks of acute infection of the respiratory tract, but there now appeared to be signs of improvement in her general condition. Treatment would obviously have to be prolonged.

**Acute Diverticulitis with Rupture.**

Dr. S. L. SPENCER showed a patient who had a rupture of an acutely inflamed diverticulum treated by oversewing, the intraperitoneal use of sulphanilamide, and a temporary colostomy. The patient, a male, aged fifty-seven years, had been admitted to hospital in August, 1941, complaining of epigastric pain and vomiting of twenty-four hours' duration. He had taken castor oil before coming to hospital.

On examination, he showed obvious signs of generalised peritonitis. At operation the peritoneum was widely inflamed, and the sigmoid colon was found to have ruptured at the base of an acutely inflamed diverticulum. The rupture was oversewn and sulphanilamide powder was sprinkled into the peritoneal cavity. A temporary left inguinal colostomy was established to act as a safety-valve, and this was later closed. The patient had since enjoyed good health.

Dr. Spencer said that interesting features were the intraperitoneal use of sulphanilamide and the fact that the ruptured diverticulum appeared to be a solitary one. As far as could be seen at operation without injudicious handling, the remainder of the colon appeared normal, and the patient at the time of the meeting showed no symptoms of diverticulitis.

**Megacolon.**

Dr. Spencer's second patient was a girl, aged nine years, who had suffered from obstinate constipation since birth, having often gone for two weeks without a bowel action. X-ray examination after a barium enema disclosed gross dilatation of the rectum. There was dilatation of the remainder of the colon, but the rectum appeared to be mainly affected. Dr. Spencer regarded this as a point of some interest, as in most cases he had encountered the dilatation of the bowel occurred mainly above the pelvi-rectal junction. Some authorities confirmed this opinion; but others, including Hurst, held that the rectum was always primarily involved. The patient was being treated conservatively by the use of aperients and enemata, and by dilatation of the anus, and she had shown considerable improvement.

**Burn of an Orbit.**

Dr. Spencer then showed a boy, aged seventeen years, who had sustained multiple injuries after falling under an electric train. One injury of practical interest was a burn of the left orbit. All the tissues bounded by the orbital margins were coagulated, and it was thought that the burns had

probably been caused by an electric current. The area involved was now covered by granulations, behind which the *globus oculi* could be seen to move. The patient presented an interesting problem in plastic surgery.

#### Ununited Fracture.

Dr. Spencer's last patient was a female, aged fifty-eight years, who had had an ununited supracondylar fracture of the humerus. Bone grafting had been considered, but it had been decided that the wide lower end of the humerus was too thin from before backwards to hold a bone graft satisfactorily. The patient had, therefore, been treated by the insertion of two Lane's plates, and now had firm union and about 45° of movement at the elbow over a useful range. It was fifteen months since the operation, and the plates were *in situ* and apparently being well tolerated.

#### Facial Carcinomata.

SIR NORMAN PAUL showed a male patient, aged forty-eight years, who had on the bridge of the nose a squamous carcinoma of three weeks' duration and on the left *ala nasi* a basal cell carcinoma of three years' duration. The lesions were about the same size. Sir Norman Paul pointed out that that fact illustrated the relative rates of growth of the two conditions. No keratoses or other lesions were present on the face.

#### Neurofibromatosis.

Sir Norman Paul then showed a male patient, aged fifty-three years, suffering from neurofibromatosis (von Recklinghausen's disease). The lesions were extensive.

#### Tuberculosis Cutis.

Sir Norman Paul's last patient was a male, aged sixty-one years, whose left thigh and perineum had been affected by *tuberculosis cutis*; this had disappeared with treatment, leaving some atrophic scarring. Sir Norman Paul said that the main and effective treatment had been with "Eulykol", a Burroughs Wellcome product. "Eulykol" was the phenylethyl esters of a selected fraction of the acids of hydnoearpus oil, and was sometimes designated phenylethyl hydnoearpus. It was usually administered by intradermal injection.

#### Radiological Exhibit.

DR. D. G. MAITLAND showed a number of X-ray films of general medical interest. Amongst them was a series illustrating the varied types and sizes of the female pelvis, and showing the features of classification. Some of the films gave an indication of the obstetrical problems which might be expected to arise in the more obvious forms of pelvic structural variations.

### Correspondence.

#### QUININE IN OBSTETRICS.

SIR: May not the absence of quinine from the armamentarium of the obstetrician be a veritable blessing in disguise, in forcing us to review both the methods and the indications for the induction of labour?

In recent years, the practice of ordering "medicinal stimulation" has become increasingly prevalent, and many a normal case has been converted into one abnormally painful, wearisome and prolonged. Many patients are subjected to repeated treatments, solely because they have gone past the calculated date, which results in much unnecessary worry to both patient and medical attendant when it proves unsuccessful.

The induction of labour should not be undertaken lightly, but when it is definitely indicated, it should be done by the most efficient method, which, as Professor Bruce Mayes has pointed out, is by artificial rupture of the membranes followed by small doses of pituitrin. With very rare exceptions, there are only two indications for its use, namely, (a) renal conditions including toxæmia, chronic nephritis, hypertension and pyelonephritis, and (b) previous dystocia due to moderate degrees of disproportion. In these cases, there is no disproportion and it does not matter if the head is "floating", the induced labour can be expected to be straightforward, though at times the onset may be delayed. The case of the *primipara* who is apparently going over-time, and where it is feared that "the child is growing

bigger, its head is getting harder, and it will die of post-maturity", is entirely different, and induction by any method should not be used. Should the head be fixed, there is little need to worry, while if the head is unfixed, and it seems as though there may be disproportion—the commonest cause being a posterior occipital position which needs correction by Buis's pads—then induction introduces a definite danger to both mother and child, and should be replaced by trial labour.

I cannot agree with Professor Mayes that "no quinine in obstetrics means a medical austerity of war", unless he includes it in the same category as beer and tobacco. They are all soothing syrups for peace-time phillandering.

Yours, etc.,

W. IVON HAYES.

Melbourne,

November 14, 1942.

#### THE RORSCHACH TECHNIQUE OF PSYCHODIAGNOSIS.

SIR: In recent years there has been a remarkable development of interest in the Rorschach ink blot test as a diagnostic instrument in child guidance, personnel selection, psychopathology, psychiatry, and allied fields. In 1939, psychiatrists and psychologists, using the Rorschach method, formed a professional organization, the Rorschach Institute Incorporated (with headquarters in New York), to serve as a clearing house for information on research, for the conduct of training courses, and for the safeguarding of professional standards.

An authorized regional division of the Rorschach Institute is now being established in Australia with a view to furthering the objectives cited above. Psychiatrists and others interested in the Rorschach method are invited to communicate with me at Younger Court, Kew, Melbourne, or with P. H. Cook, M.A., Ph.D., Queen's College, Carlton, Melbourne.

Yours, etc.,

D. F. BUCKLE, M.B., B.S., D.P.M.

Melbourne,

October 13, 1942.

#### ASTHMA AND THE USE OF MORPHINE.

SIR: Recently in "Current Comment" timely attention was drawn to the dangers of morphine used to relieve paroxysms of asthma. Too much emphasis cannot be laid on Coca, Walzer and Thommen's statement that it is useful only "when other measures have failed". Attention should also be drawn to dosage; the cough reflex should not be abolished and Bray is of the opinion that more than a quarter of a grain should not be given. He uses morphine in "status asthmaticus" in very small doses given along with adrenaline: two solutions are used, "A" of adrenaline chloride solution (1/1,000), "B" of morphine sulphate a quarter of a grain, atropine sulphate 1/100 grain, adrenaline chloride solution (1/1,000) to 10 minims. One minim of solution "A" is given each minute, but every fifth minute one minim of solution "B" is substituted. Not more than 10 minims of "B" solution (that is, one-quarter morphine sulphate) are used in all, and usually this dose is unnecessary.

Bray's method of using morphine is used as a last resort in the Royal North Shore Hospital of Sydney. Patients requiring admission more than once, quickly get to know that "B" solution makes them feel more comfortable and the desire, if gratified, may quickly become a habit hard to break. It should never be used in children of less than ten years of age.

It is a problem then to deal with "status asthmaticus" and patients who are "adrenaline fast" without using opiates. It is far easier to relieve a paroxysm of asthma by a small dose early than a large dose late in the attack. Patients who use adrenaline themselves should be taught to give it early and give it slowly. Adrenaline acts so quickly that if the hypodermic needle is left *in situ*, and one minim injected each minute till relief is felt, the unpleasant side effects—palpitation, tremor, coldness of the extremities *et cetera*—may be avoided and broncho-spasm relieved.

Aminophyllin (U.S.P. Theophylline with Ethylene) is a most useful drug in the treatment of cases that are resistant to adrenaline: 0.48 grammes in 20 cubic centimetres of saline solution given intravenously and slowly is often of immediate benefit. This dose is recommended by American



observers and in our cases has proved of great value. Drug Houses of Australia make up 10 cubic centimetre ampoules containing 0.24 gramme. Why 0.48 and 0.24 grammes are used instead of 0.5 and 0.25 I do not know. This drug should certainly be tried before resorting to morphine. Its main action is to dilate peripheral blood vessels and quite possibly it is beneficial because it counteracts the vasoconstriction that results from large doses of adrenaline. Incidentally, hypertension associated with asthma is not a contraindication to the use of adrenaline.

Other procedures worthy of trial in "status asthmaticus" are venesection and ether anaesthesia. Venesection is indicated in the presence of extreme cyanosis and may be followed by great improvement. Anaesthesia is not without danger; the cough reflex is, of course, abolished, but the relaxation of the bronchial musculature more than compensates for this loss and much relief is obtained from the subsequent vomiting and coughing of mucus. Like morphia, it should be one of the last measures tried. Administration of an ether and olive oil enema induces a light anaesthesia, but open ether is usually preferable. "Avertin" has been found useful by several observers. It is interesting to note that R. J. S. McDowall (Professor of Physiology, King's College, London) casts doubt on the belief that chloroform plus adrenaline is apt to bring about cardiac fibrillation (*British Medical Journal*, July 12, 1941).

The barbiturates are useful adjuvants, relieving the "angor animi" that may occur with asthma as well as with severe cardiac pain and inducing sleep as the paroxysm becomes milder.

Until the time comes when a drug is elaborated that can be taken by mouth, will act quickly with no side effects, and will produce the effect that adrenaline does when given hypodermically, the symptomatic treatment of asthma will remain difficult. It is more difficult still when the asthmatic is a morphia addict, and even if the use of morphia were quite void of danger to life, it should still be used as seldom as possible because of the likelihood of addiction occurring in such a chronic complaint.

Yours, etc.,

K. O. JONES,

Acting Physician in Charge of  
Allergy Clinic, Royal North  
Shore Hospital of Sydney.

143, Macquarie Street,  
Sydney,

November 23, 1942.

#### TRIGEMINAL PAIN AND ABDOMINAL DEPRESSION.

SIR: I am wondering if any of the readers of your journal knows what connexion there can be between trigeminal pain and a sensation of deep depression in the abdomen. That this connexion exists I am absolutely certain. I have had the trigeminal pain constantly, more or less severely for over fifteen years, but this abdominal sensation is new, of about twelve months' duration. It precedes and accompanies the severe spasms of pain, and the deeper the sensation of depression, the more severe the pain which will accompany it. The sensation is somewhat like that which occurs after one has not quite regained his breath after a blow in the abdomen, but lasts for an hour or more. If any one of your readers has had experience of anything similar and knows how to treat it, I should be extremely grateful to hear from him.

Yours, etc.,

ALEC. LYONS.

Egglehawk,

Victoria,

November 20, 1942.

#### WAR WOUNDS.

SIR: Your reviewer (November 14, 1942) makes reference to the struggle between the chemical and physiological schools of treatment of wounds. Undauntedly I protest again that there never should have been any conflict. Wright did a great service by his research into the physiological defences of the body and endeavoured to give us a measure of them. Nobody denies the value of the natural barriers to infection, yet, in practice, little reliance is placed upon them. The absolute dependence on the sulphanilamides to destroy, subvert or render harmless infective agents is an example of this. No drug has yet been found that will effectively discharge this service. Some day it may arrive,

but until then we would be better advised to combine chemical agencies with natural defences in an intelligent manner. The extraordinary statement is made by your reviewer that the common antiseptics are practically useless in the treatment of infected wounds. That is true only when used within the wound and nobody nowadays ever thinks of any alternative. The proper place for antiseptics is outside the wound and not within it where they are harmful—except the sulphanilamides, I will allow to a degree. As a component part of the dressing of a wound antiseptics have the important office of preventing the entry of infection and the offensive and defensive units within the wound have assigned to them the duty to destroy all invaders which with rare exceptions they are quite capable of doing, but only when reinforcements are excluded with certainty. Properly managed all wounds are self-cleansing. There should be no war between methods, but clear compromise and mutual aid, the coordination that will even win wars.

Yours, etc.,

A. C. F. HALFOED, M.D., F.R.A.C.S.

Brisbane,

November 16, 1942.

### Naval, Military and Air Force.

#### APPOINTMENTS.

THE following appointments, changes *et cetera* have been promulgated in the *Commonwealth of Australia Gazette*, Number 304, of November 19, 1942.

#### PERMANENT NAVAL FORCES OF THE COMMONWEALTH (SEA-GOING FORCES).

**Termination of Appointment.**—The appointment of Surgeon Commander Hill Gillman Wells is terminated on reversion to the Royal Navy, dated 24th October, 1942.

**Firing Rates of Pay.**—Surgeon Lieutenant-Commander (D) Dudley Ormond Southby to be paid the rates of pay and allowances prescribed in the Naval Financial Regulations for Surgeon Commander (D) (on promotion), whilst acting in that rank, dated 23rd October, 1942.

**Ante-dating Seniority.**—The seniority of Surgeon Lieutenant (D) Allen Walton Hexter is ante-dated to 1st November, 1938.

#### ROYAL AUSTRALIAN AIR FORCE.

##### Citizen Air Force: Medical Branch.

The following temporary Squadron Leaders are granted the acting rank of Wing Commander whilst occupying Wing Commander posts with effect from 1st October, 1942: S. G. Preston (1194), C. H. C. Searby (2041), J. J. W. Flynn (1268), K. G. Colquhoun (3232).

The following Flight Lieutenants are granted the acting rank of Squadron Leader whilst occupying Squadron Leader posts with effect from 1st October, 1942: A. W. Bayley (1886), J. F. Hughes (2290), G. B. Morris (2082).

Flight Lieutenant C. G. Davidson (1283) relinquishes the acting rank of Squadron Leader on ceasing to occupy a Squadron Leader post with effect from 28th September, 1942. —(Ex. Min. No. 184—Approved 13th November, 1942.)

The following temporary Flight Lieutenants are granted the acting rank of Squadron Leader whilst occupying Squadron Leader posts with effect from dates indicated: J. A. Bond (1488), 1st August, 1942; M. A. Lloyd-Jones (1859), 23rd August, 1942. —(Ex. Min. No. 188—Approved 13th November, 1942.)

The following officers are transferred from the Reserve, with effect from the dates indicated: (Flight Lieutenants) H. E. Williams (5176), M. J. M. Black (5944), 24th August, 1942; V. W. Potter (2875), 26th August, 1942; R. E. Hearn (6390), 27th August, 1942.

The following are appointed to commissions on probation with the rank of Flight Lieutenant, with effect from 24th August, 1942: Vincent Wilfred John O'Reilly, M.B., B.S. (6733), Earle Fead Northcroft, M.B., B.S., M.Sc., Ph.D. (6734).

##### Reserve: Medical Branch.

The following are appointed to commissions on probation with the rank of Flight Lieutenant with effect from the dates indicated: Howard Stewart Moore, M.B., B.S. (6931), Harold Roberts Thomson, M.B., B.S. (6874), 5th October, 1942; Alan Ingram Lane, M.B., B.S. (6930), 6th October,

1942, Norman John Chamberlain, M.B., B.S. (6869), 7th October, 1942, Clifford Kenneth Hemmingway, M.B., B.S. (6936), 15th October, 1942.—(Ex. Min. No. 179—Approved 13th November, 1942.)

Flight Lieutenant D. A. Carter (2744) is transferred from the Active List with effect from 31st January, 1942.—(Ex. Min. No. 187—Approved 13th November, 1942.)

Horace George Norton, M.B., B.S. (6732), is appointed to a commission on probation with the rank of Flight Lieutenant, with effect from 20th August, 1942.—(Ex. Min. No. 191—Approved 13th November, 1942.)

### CASUALTIES.

ACCORDING to the casualty list received on November 25, 1942, Captain P. C. R. Goode, A.A.M.C., Lower Mitcham, South Australia, is reported to have been wounded in action, remaining at duty.

According to the casualty list received on November 25, 1942, Major J. F. Akeroyd, A.A.M.C., Frankston, Victoria, who was previously reported missing, believed prisoner of war, is now reported to be a prisoner of war.

According to the casualty list received on November 25, 1942, Major T. R. Matson, A.A.M.C., St. Klida, Victoria, is reported removed from the "seriously ill" list.

### DECORATIONS.

Surgeon Lieutenant Shane Andrew Clarke Watson, R.A.N.R., has been awarded the Distinguished Service Cross.

## Australian Medical Board Proceedings.

### NEW SOUTH WALES.

THE undermentioned have been registered, pursuant to the provisions of the *Medical Practitioners Act*, 1938-1939, of New South Wales, as duly qualified medical practitioners:

- Mulvey, Eric William, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.
- Musso, Anthony Fidelis Vincent, M.B., B.S., 1942 (Univ. Sydney), Saint Vincent's Hospital, Darlinghurst.
- Norton, Horace George, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.
- Ople, James Gordon, M.B., 1942 (Univ. Sydney), District Hospital, Balmain.
- O'Shea, Brian Daniel, M.B., B.S., 1942 (Univ. Sydney), Saint Vincent's Hospital, Darlinghurst.
- Oxenham, Brian Bede, M.B., 1942 (Univ. Sydney), Lewisham Hospital, Lewisham.
- Oxenham, Gordon Vincent, M.B., 1942 (Univ. Sydney), Saint Vincent's Hospital, Darlinghurst.
- Parker, Anthony Owen, M.B., B.S., 1942 (Univ. Sydney), Sydney Hospital, Sydney.
- Parker-Smith, Winston, M.B., 1942 (Univ. Sydney), Women's Hospital, Crown Street, Sydney.
- Peipman, Eskil Valno, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

### Obituary.

#### JOHN MACPHERSON.

We regret to announce the death of Sir John Macpherson, which occurred at Bristol, England, on August 14, 1942.

## Nominations and Elections.

THE undermentioned has applied for election as a member of the Tasmanian Branch of the British Medical Association: Simpson, John George, M.B., B.S., 1941 (Univ. Melbourne), Captain J. G. Simpson, 12th Australian Field Ambulance, Australian Army Medical Corps.

## Books Received.

"The Mental Nurse's Dictionary", by E. L. Hopewell-Ash, M.D. (London): 1942. London: Faber and Faber. 7½" x 5", pp. 138. Price: 5s. net.

"Gray's Anatomy Descriptive and Applied", edited by T. B. Johnston, M.D., and J. Whillis, M.D., M.S.; Twenty-Eighth Edition: 1942. London: Longmans, Green and Company. 18" x 6½", pp. 1576, with 1,347 illustrations, of which 631 are in colour. Price: 60s. net.

"The 1942 Year Book of Radiology", edited by C. A. Waters, M.D., W. B. Firor, M.D., and I. I. Kaplan, B.Sc., M.D.: 1942. Chicago: The Year Book Publishers, Inc. 9" x 6", pp. 496, with many illustrations. Price: \$5.00, post paid.

## Diary for the Month.

- Dec. 8.—New South Wales Branch, B.M.A.: Ethics Committee.
- Dec. 8.—Tasmanian Branch, B.M.A.: Branch.
- Dec. 9.—Victorian Branch, B.M.A.: Council.
- Dec. 10.—New South Wales Branch, B.M.A.: Branch.
- Dec. 11.—Queensland Branch, B.M.A.: Annual Meeting.
- Dec. 15.—New South Wales Branch, B.M.A.: Medical Politics Committee.
- Dec. 18.—Queensland Branch, B.M.A.: Council.
- Dec. 25.—Tasmanian Branch, B.M.A.: Council.

## Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

**New South Wales Branch** (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Nurses' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phoenix Mutual Provident Society.

**Victorian Branch** (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

**Queensland Branch** (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

**South Australian Branch** (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

**Western Australian Branch** (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia.

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